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Understanding Commercially Sexually Exploited Youths' Facilitators and Barriers Towards Contraception Use: *I Didn't Really Have A Choice*

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Abstract

Study Objective: Given the high reproductive health risks that commercially sexually exploited youth (CSEY) face, we sought to understand facilitators and barriers related to their utilization of both condoms and hormonal contraception.

Design: We conducted semi-structured interviews with 21 females identified as CSEY. Interviews were audio-recorded, transcribed, and coded for emergent themes. Participants were enrolled through group homes and a juvenile specialty court serving CSEY.

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Results: Overall, CSEY reported relatively easy access to both hormonal contraception and condoms, expressing a strong preference for condoms as their primary form of contraception. Most respondents described an aversion towards hormonal birth control, attributed to personal experiences and peer accounts of side effects. Many also shared a common belief that hormonal methods are "unnatural," cause infertility, and have low efficacy. Although youth expressed a preference for condom use, they also reported frequent unprotected sex. Furthermore, there were notable barriers to hormonal contraception and condom use that were specific to youths' sexual exploitation, primarily due to their lack of control while trafficked.

Conclusion: While participants noted relatively easy access to contraception, a number of barriers to both condoms and hormonal contraceptive utilization exist. Many of these barriers align with youth identified in other at-risk adolescent populations, however, CSEY also face a number of barriers that may be attributable to their unique experience of commercial sexual exploitation. Contraceptive education that dispels prevailing myths, sets clear expectations regarding side effects, and emphasizes autonomy is most likely to resonate with their worldview and experiences.

Keywords

Adolescent; Child Abuse; Human Trafficking; Contraception; Pregnancy

INTRODUCTION

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) defines the commercial sexual exploitation of children as "crimes of a sexual nature committed against juvenile victims for financial or other economic reasons."[1] No reliable data exist on the exact prevalence of commercial sexual exploitation of children,[2] partly due to the hidden nature of commercial sexual exploitation, reluctance of victims to disclose their status, and lack of systematic data collection.[1] Risk factors for commercial sexual exploitation include child welfare involvement; history of homelessness or running away; history of child abuse or neglect; identification as lesbian, gay, bisexual, transgender, or queer; family dysfunction; gang involvement; and living in high crime neighborhoods.[3]

Commercially sexually exploited youth (CSEY) are among the highest need adolescents within the United States.[1] As a result of their exposure to commercial sexual exploitation and tumultuous trauma histories, CSEY often experience a number of interrelated medical and mental health disparities such as violence-related injuries, depression, post-traumatic stress disorder, and substance use disorders.[1] Due to risky behaviors (e.g. unprotected sex, sex while intoxicated), reproductive health needs among CSEY, especially related to sexually transmitted infections (STIs) and unplanned pregnancy, are high.[3,4]

CSEY have a high likelihood of arrest and incarceration, making them an especially high-risk group within the larger juvenile justice population, a group with documented high reproductive health needs.[1] Past studies have shown that 20 to 48% girls detained in the juvenile justice system have tested positive for an STI.[4] Furthermore, more than 30% of detained girls have been pregnant at some point, compared with a national average of 4.3% among adolescent girls in the general population. [4] Given the confluence of their risk-taking

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behaviors, STI and pregnancy rates among CSEY, many of whom are judicially involved, are likely even higher.

These disparities make CSEY a population of great public health significance with high disease burden. Available literature on the medical needs of CSEY, although sparse, has focused on reproductive health and contraception use among adult survivors of commercial sexual exploitation.[5,6,7] A study involving female survivors of commercial sexual exploitation (n=21, age range 18–60 years) detained in a New York City jail described survivors' contraception use while trafficked. Condoms were identified as the most common form of contraception.[6] Additionally, one of the largest studies involving female survivors of commercial sexual exploitation (n=107, age range 14–60) found that while trafficked, 71% reported at least one pregnancy, 21% reported five or more pregnancies, 55% reported at least one abortion, 30% reported multiple abortions, and 55% had at least one miscarriage.[5] Several participants with histories of pregnancy reported at least one forced abortion by their trafficker.[7]

While numerous studies have shown that CSEY often interact with healthcare providers, before, during, and after their exploitation, many medical trainees and practicing physicians have expressed a lack of knowledge regarding CSEY and their distinct needs.[8] Reproductive healthcare, however, can be as a gateway for engaging CSEY in healthcare.[9,10] Yet, despite the documented high reproductive health needs among CSEY,[4,5] there remain large gaps in knowledge on their views of contraception. Factors driving preferences around contraceptive decision-making for CSEY are unclear. To our knowledge, no prior studies have focused on CSEY's experiences with contraception from the youths' perspectives. Given the high reproductive health risks within this population of vulnerable adolescents, we sought to better understand CSEY's attitudes and beliefs towards hormonal contraception and condom use in order to better inform the medical community about the health needs of CSEY.

MATERIALS AND METHODS

Design

We conducted this community-partnered, in-depth qualitative research study in partnership with diverse entities serving CSEY, which included a specialized juvenile delinquency court, two group home agencies, and a service provider agency. To optimally gather CSEY's views on contraception, we strove to create a trusting environment in which participants felt they could openly discuss their life experiences and preferences related to hormonal contraception and condom use.

Population Sample and Selection

We initiated recruitment of study participants by sending our study materials to our four study partners (two residential group homes, a juvenile specialty court, and a community-based CSEY service provider organization). All of our community partners provide care, supervision, and/or services to youth identified as CSEY. Our recruitment process occurred as follows. We informed the partners of our study eligibility criteria: (1) age older than 12, (2) age less than 23, and (3) youth responding yes to the question: "Have you traded sex for

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something of value?". Our community partners then informed youth likely to screen eligible for the study about the research study. If youth expressed potential interest in participation, the community partners informed the study team. The study team then contacted the youth and set up an in-person meeting to verify interest. If youth indicated interest, the team proceeded with the informed consent and screening processes. The screening process entailed a 3-item written survey completed by youth, as summarized above (i.e., ages 13–22 and self-report of trading sex for something of value).

Throughout the study, we use the term CSEY to refer to our study population of commercially sexually exploited youth, all of adolescent age, including transitional age youth. Although males would have been potentially eligible per our recruitment and screening procedure, all youth recruited were female. This was not surprising given the demographics of the CSEY served by our partnering organizations, which is heavily skewed towards females. All respondents accessed services through at least one of our community partners during the study period. Participants self-disclosed previous or ongoing involvement in commercial sexual exploitation (or "the life," as referred to by the youth). Pathways in and out of commercial sexual exploitation are known to be cyclical, as many youth relapse into patterns of exploitation multiple times before permanent exit;[11] most participants had last been commercially sexually exploited within the prior year or two. Interviews were confidential and all participants provided informed consent. Youth were informed by the study team as well as partner agencies that their participation was voluntary and that they could end their participation at any time.

Data Collection

We collected data through one-on-one, semi-structured interviews from March 2017 through July 2017. The voluntary interviews were conducted in a private area in the group home, specialty court, or in the community. Interviews ranged from 30 to 60 minutes and were guided by an interview protocol that consisted of open-ended questions related to contraceptive preferences, access to reproductive services, and condom use. Questions were developed to build on findings from a previous focus group study conducted by members of the research team.[10] Participants also completed a demographic survey with information about their age, identified gender, race, and housing status. Each participant received a $25 gift card and snack food items in appreciation of their time and involvement. All study procedures received approval from our university's institutional review board and from the superior court's juvenile division. Interviewers were trained to respond in the event that interviews caused emotional distress and a child psychiatrist was available for consultation. Many of the participants were under the direct supervision of the group home/juvenile hall, with support services available if needed.

Analyses

With the participants' consent, we audio recorded each interview. Following the interview, recordings were professionally transcribed and all personal identifiers were removed. Interviewers and coders were trained in qualitative research methodology with an expert in the field through several qualitative methods training sessions. The team performed thematic analysis on the interview transcripts utilizing Dedoose software.[12] To develop the codebook,

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all research team members (six individuals) independently coded three interview transcripts. The team then met to develop a preliminary codebook, discussing and resolving all discrepancies. The team collectively developed codes and code definitions. Two members of the research team coded each transcript independently, and the full team resolved disagreements. Points of overlap and contention among themes were discussed and refined in weekly research meetings. Interviews were continued until saturation of themes was reached.[12] When coding was complete, the team met together for several analytic sessions during which the codes were organized into emergent themes. To assess the truthfulness of our results, we debriefed findings with community partners who consistently engage with CSEY (e.g. lawyers, probation staff, social workers) as well as with partners in pediatrics and psychiatry, all of whom were not members of the study team.

RESULTS

Participant Demographics

Twenty-one female CSEY participated in the study. The participants identified as the following races: 67% African-American, 19% White, 10% American Indian, 10% Other, 5% Asian, and 14% did not disclose their race. Among participants, 33% identified their ethnicity as Latina. The average age of participants was 17 years old (range: 15–19). 71% of participants reported homelessness in the three months prior to the interview. At the time of the interviews, 10% of participants lived in their own home/apartment; 43% lived in their parent’s home; 5% lived with a family member in a house/apartment; 14% lived in the home of a friend, “boyfriend,” or additional non-relative; 38% lived in a foster or DCFS/licensed group home; and 5% lived in a halfway house, shelter, or welfare hotel. Additionally, while not explicitly asked, youth primarily described having male sexual partners. Two youth reported having female sexual partners in addition to male sexual partners.

Facilitators and Barriers Towards Condom Use

Participants identified several facilitators and barriers to utilizing condoms (Table 1). Overall, most participants expressed that condoms were readily accessible, meaning they knew where and how to obtain low-cost or free condoms. As a result, the barriers and facilitators refer most strongly to their use of condoms, rather than access to condoms. Most participants voiced a preference for condoms over other contraceptive types, such as hormonal contraception. Furthermore, participants generally preferred condoms to no protection, although many did frequently have sex without a condom due to the identified barriers to condom use described below.

Facilitators—Facilitators to condom use included: *personal preference for condom use, sexual health education at school*, and *sexual health education with medical provider*. These identified facilitators to condom use were present both during and after exploitation. However, facilitators appeared more instrumental for youth who were not being actively sexually exploited. When not being exploited, youth described having more control over their reproductive decisions, specifically feeling they had more power to request or insist on condom use. The facilitator, *personal preference for condom use* was consistent for youth, both when they talked about being exploited and when they reflected on no longer being

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exploited. Additionally, the identified facilitators, prior receipt of *sexual health education at school* and *sexual health education with medical provider* emerged as factors that encouraged youth to utilize condoms when they had the autonomy to do so, both during and after commercial sexual exploitation.

Barriers—Identified barriers to condom use included: *questionable reliability, negative influence of sexual partner, no identified need, trafficker control, condom use not a priority,* and *sexual violence.* Participants perceived that condoms had *questionable reliability*, as they experienced condoms "popping" or "breaking" during use. Participants also noted the *negative influence of sexual partner* as a significant barrier, with several expressing that many partners "[didn't] like using protection while having sex." Additionally, participants viewed condoms as unnecessary for several reasons. Firstly, some youth expressed being in relationships of *perceived monogamy* where condoms were not deemed necessary. Secondly, some youth expressed a *perceived inability to become pregnant* after pregnancy did not occur following numerous incidents of unprotected sex. Thirdly, some youth described a *perceived ability to prevent pregnancy and sexually transmitted infections without condoms* via other means, such as bathing. Lastly, some youth cited abstinence as their primary method of contraception once they were no longer being exploited. When asked about current sexual activity, one youth expressed disdain toward potential sexual partners, stating "leave me alone, get away from me. I don't want you right now."

Barriers to condom use that were specific to youth while exploited were *trafficker control, not a priority,* and *sexual violence*. Youths' lack of control during exploitation is demonstrated through one participant's statement, she explains,

> "When you're being trafficked, you're not really doing it because you want to. You're doing it because you're either going to get hurt or killed because you say no. So it's more-so against your will."

CSEY expressed that they were often under complete control of their trafficker, meaning that even if they had access to condoms, they were often not allowed nor felt safe to utilize them. As one participant stated, "at that point in time, I didn't really have a choice [to use condoms]." Additionally, while being exploited, condom use was often *not a priority,* because youth were focused on their day-to-day survival instead of STI and pregnancy prevention. As one youth stated, "in the life using condoms hadn't crossed my mind." Furthermore, sexual violence occurred frequently and several CSEY strongly asserted that they did not have control over whether or not a condom was used. As one participant recalled, "This trick raped me. He wouldn't be nice enough to use a condom." Unfortunately, participant reports of sexual violence were not uncommon.

Facilitators and Barriers Towards Hormonal Contraception

Participants identified key barriers and facilitators to utilizing hormonal contraception (Table 2), several of which overlapped with the barriers and facilitators for condom use. Similar to condom use, the facilitators to hormonal contraception use were consistent regardless of which stage of exploitation the youth were describing at that point in the interview; however, in contrast, some barriers were uniquely related to their experiences of being exploited. As

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with condoms, youth had relatively easy access to hormonal contraception, and key facilitators and barriers had a profound impact on their utilization of hormonal contraception.

Facilitators—Facilitators to hormonal contraception use were: *not having a period, appreciation of long-acting reversible contraceptive (LARC) methods, confidence in birth control method, communal support,* and *autonomy.*

Some participants valued *not having a period* due to hormonal contraception, because the menstrual cycle was reported as a source of distress. Participants noted that obtaining menstrual pads and tampons were particularly a challenge while exploited. Because they were under the control of their trafficker, they often did not have access to their own money and had to rely on their trafficker or other CSEY for feminine hygiene supplies. Furthermore, some participants had an *appreciation of LARC methods,* as they did not require them to remember to consistently take or "swap out" their method on a regular basis. This was particularly helpful during times of exploitation, where youth were at high risk for homelessness, making the task of having birth control supplies on-hand a serious challenge. Several CSEY also valued having *confidence in their birth control method,* expressing that they were taught and subsequently believed that certain methods (e.g. IUD and Nexplanon) were more effective than others. *Communal support* of hormonal contraception use from family members and group home staff was also important in initiating a contraceptive method. Finally, participants who felt that the use of hormonal birth control was their decision (as opposed to their provider's decision) were more likely to use hormonal birth control.

Barriers—Despite the aforementioned facilitators, nearly all participants demonstrated aversion to hormonal contraception. Barriers to hormonal contraception included the common belief that *birth control was unnatural, concerns about efficacy,* and *concerns about impact on fertility.* Additionally, youth noted barriers due to *side effects, feeling forced,* and *no identified need.*

Many CSEY shared the belief that *birth control is unnatural*, and were thus, hesitant to put "anything inside [their bodies]." Many also shared *concerns about efficacy.* One youth referenced "stories where people got pregnant on birth control," as a reason for not initiating use. Youth also shared *concerns about impact on fertility*, with statements such as, "I don't like birth control. I think it's going to mess up when I want to have a kid, like it's going to mess up my count or something." Several participants attributed their aversion to use to personal experiences and peer accounts of *side effects* such as irregular bleeding, nausea, cramping, and weight gain, with statements such as "I just don't like the way [birth control] makes my body feel." An additional barrier to hormonal contraception use was *feeling forced* to utilize birth control. One young woman described receiving the Depo-Provera injection without her consent, which led to a strong disinclination towards future use. Another felt pressured by medical providers to use hormonal contraception, stating that "They always be like forcing you, pushing you to get it." Last, some participants had *no identified need* for hormonal contraception due to their decision to be abstinent once no longer exploited.

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CSEY Attitudes Towards Pregnancy

The participants described their attitudes towards potential and/or past pregnancies. Coupled with their aversions to hormonal contraception and barriers towards condom use, several youth expressed an attitude towards potential pregnancy of "If it happens, it happens," (Figure 1). These youth did not feel contraception was necessary since unplanned pregnancy was not of high concern. While these youth were not actively seeking pregnancy, concerns about unplanned pregnancies appeared minimal. Of CSEY who had been pregnant, there were a variety of sentiments expressed towards their experiences. Some youth reported feeling like a disappointment for becoming pregnant at a young age. Others felt that their baby was a blessing, noting that the birth of their child stimulated positive behavior change. For example, one participant stated that having a baby kept her from "AWOLing" (i.e., running away from placement). Another youth noted that it encouraged her to "get out of the life," and "keep [herself] away from drama." For these girls and young women, the baby was their priority. Additionally, some participants noted isolating and fearful experiences with pregnancy, describing a lack of support ("I felt alone") and not feeling ready to parent. CSEYs' attitudes towards pregnancy may have larger implications regarding their contraceptive choices and decisions.

Recommendations from CSEY—CSEY had a number of recommendations for improving reproductive healthcare and interactions with providers (Table 3). Recommendations included: provide additional sexual health education, increase social media outreach and receipt of health information via technology, advertise services available, lower the cost of reproductive health supplies, and provide basic necessities in the medical setting. Notably, while those who had taken sexual health education in their school experienced that knowledge was a facilitator to contraceptive use, many did not receive this exposure. As a result, these youth requested additional sexual health education, stating that this information "may be in certain schools, but not the schools [they] go to." Participants also reflected on their past reproductive health questions, such as "could I catch HIV" or "can I breastfeed my baby?" During these instances, youth identified feeling "scared" and desiring more "information about STI prevention and how it [contracting STIs] can happen." To enhance education outreach, they also suggested increasing social media outreach and the dissemination of health information via technology, stating "everyone's obsessed with their phones nowadays." While participants noted relatively easy access to reproductive health services, they also recommended that health centers should improve marketing of available services and lower the cost of supplies such as pregnancy tests. Lastly, many CSEY requested that reproductive health centers provide basic necessities in medical settings. The provision of basic necessities such as sanitary supplies and hygiene products would be especially helpful for CSEY who did not have their own money or other means of accessing needed items.

DISCUSSION

Overall, we found that while CSEY reported relatively easy access to condoms and hormonal contraception, they described a number of barriers related to use, such as *concerns about efficacy and side effects* in relation to hormonal contraception and *trafficker control* in

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relation to condom use. Some of these identified barriers to contraceptive use coincide with other female adolescent at-risk populations. Our findings suggest that access to contraception alone is not sufficient as CSEY face many barriers to utilization, including barriers specific to their histories of commercial sexual exploitation that may be dangerous or extremely challenging to overcome.

Differences between CSEY and Other At-Risk Youth

CSEY Trauma and Contraception Use—The experience of commercial sexual exploitation had a profound impact on participants' ability to use contraception while exploited as well as their views on contraception after being exploited. A number of study participants experienced sexual violence and other forms of trauma while trafficked. Several youth described no need for contraception after exploitation due to the desire for abstinence. The resolute decision to be abstinent may be a reaction and coping method to the trauma experienced during exploitation. This resolute decision is consistent with experiences of childhood sexual abuse survivors who, studies have shown, may become resolutely abstinent in their adult years following sexual trauma experienced in childhood.[13] Within our sample, youth who stated a decision to be abstinent frequently described having unprotected sex. The mismatch between their stated preferences and behaviors may pose a challenge to providers involved in their reproductive health counseling. Furthermore, more invasive methods of contraception that require a vaginal exam, such as an intrauterine device (IUD), may elucidate memories of past vaginal trauma.[13] These points should be taken into consideration as providers counsel and work with these adolescents to identify their best treatment plan. Findings support that a trauma-informed approach is most likely to be effective; providers will need to be aware of the unique needs of CSEY, understanding that behaviors that may seem hypocritical or even irresponsible, such as risky sexual behavior, may be a coping mechanism for profound trauma.

CSEY and Reproductive Justice—The concept of "reproductive justice" can be applied to better understand the ways in which CSEY's reproductive health needs may differ from other at-risk teens. The term reproductive justice describes struggles that marginalized women and girls must navigate in order to effectively access reproductive health education and services.[14] Reproductive justice calls for solutions to the intersecting oppressions that women and girls within marginalized communities face. While many barriers to contraception experienced by female CSEY may be similar to their adolescent peers, the various identities of CSEY (e.g., mostly from minority groups, commercial sexual exploitation, formerly homeless or runaway, childhood abuse survivors, systems-involved), are embedded in their reproductive health needs, many of which may interrelate to unmet mental health needs. How should providers address these overlapping identities, all of which convey vulnerability and health disparities? Current research encourages reproductive health providers to facilitate autonomy with their patients in selecting a contraceptive method.[10] For CSEY who have past histories of trauma and abuse, emphasizing adolescents' autonomy during contraceptive counseling and initiation is likely imperative. Providers should be attuned to the unique trauma histories of these youth and realize that CSEY may feel especially resistant to "feeling forced" to utilize a specific method. Given CSEY's histories of lack of control, it is especially imperative that reproductive health providers interact

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collaboratively with their commercially sexually exploited patients, remaining patient and flexible throughout the process.

Similarities to Other At-Risk Youth

Several similarities regarding barriers to contraception use exist between our sample and other studies with at-risk adolescent girls. When no longer exploited, CSEY described relatively easy access to hormonal contraception and condoms. This is consistent with studies of other at-risk youth their age.[16,17] In regards to hormonal contraception, studies with other at-risk adolescent girls similarly found that barriers to use included youth not wanting a foreign object inside their body, viewing birth control as unnatural, fear of impaired fertility, fear of side effects (e.g., weight gain, irregular bleeding, etc.), lack of identified need, and peer accounts of side effects while utilizing a method. [17,18] Additionally, amongst other at-risk adolescent girls, negative partner influence has also been shown to decrease likelihood of condom utilization.[18] The observed similarities between female CSEY and other adolescent girls can serve as a reminder that, in many respects, commercially sexually exploited adolescent girls may have a lot in common with their peers. Meanwhile, their differences can remind us that CSEY can be viewed as an extreme example of the risks and manifestation of intense, repeated trauma among adolescent girls.

Steps Forward

Professional medical societies such as the American Academy of Pediatrics have recognized the importance of developing trainings and policies that raise awareness about human trafficking.[19] Additionally, the available research suggests the value of adopting a standardized, evidence-based, trauma-informed approach that incorporates gender, cultural competencies, and survivor input.[6,20] Yet the question remains how best to implement such an approach. Greenbaum et al. (2018) applied the Center for Disease Control's Social-Ecological model as a framework for implementing human trafficking prevention strategies for health care professionals.[18] The authors first discuss how healthcare providers can incorporate prevention strategies into their clinical work with patients and family (e.g., by providing anticipatory guidance regarding healthy sexual relationships).[21] They then discuss how healthcare providers may collaborate across sectors to implement community and society-level prevention strategies in education, advocacy, and research.[21] Consistent with the Greenbaum et al. (2018) approach, youth in our study emphasized the importance of prevention for improving the delivery of reproductive healthcare to CSEY, with suggested strategies acting at many levels of the Social-Ecological Model. For example, youth participants addressed community-level sex trafficking prevention strategies, such as the installation of billboards in high traffic areas and media awareness campaigns. Authentic partnerships with CSEY survivors to develop such programs should be explored. Additionally, CSEY discussed encouraging direct provider interactions, such as increasing one-on-one reproductive health education from providers to youth within clinical encounters.

In spite of reported access to hormonal contraception, many youth described aversions to hormonal contraception methods that indicate a lack of understanding about contraception options and their associated side effects. Thus, increasing education on the benefits of

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hormonal contraception and providers reinforcing the importance of consistent condom use is worthwhile. Many CSEY have a history of truancy or school dropout. Some CSEY may not receive exposure to the same reproductive health education available to their peers while in middle and high school due to their inconsistent school attendance or the lack of availability in the school they did attend.[17] Within our sample, not all youth had access to consistent health education from school or medical providers, however, those that did, noted a benefit.

Discussions regarding safer sex practices when engaging with a victim of sex trafficking are not currently standardized.[19] Findings suggest that when discussing safe sex with CSEY, providers should spend time exploring their patient's contraceptive preferences, making an effort to ensure that youth do not feel forced or coerced into utilizing certain methods and embracing shared-decision making, which may also include key members of the youth's support system (e.g., parents, social workers). When speaking with youth, contraceptive education that dispels prevailing myths, sets clear expectations regarding side effects, and emphasizes autonomy is most likely to be effective for this population. Of note, this information will only be useful for youth who have the autonomy to utilize condoms and hormonal contraception. Further research is needed to develop best practices for how clinicians can support youth who are actively being exploited with limited control and autonomy.

Limitations

As with all exploratory research studies, this inquiry had limitations. The transferability and applicability of our study findings is limited to the youth we were able to speak with, all of whom were under jurisdiction of the same urban county and had placements in our partnership group homes and/or were participants in a juvenile specialty court. Also, despite our team's prioritization of cultivating trust with the youth, lack of trust may have been an issue, especially regarding sensitive topics such as abortion. Furthermore, our sample did not include male or transgender CSEY and this remains an underexplored group and a valuable opportunity for future research, especially regarding condom use. Additionally, the information that we collected from youth was cross-sectional or represented their feelings surrounding contraception at one time point. It is possible that their views and beliefs will change over time. As such, a longitudinal exploration of their perspectives may glean additional information and is an opportunity for further exploration.

Conclusions

Commercially sexually exploited youth experience a number of reproductive health risks and have high, unmet reproductive health needs. Their experiences of commercial sexual exploitation also pose distinct barriers to their utilization of available reproductive health services. Medical providers who are attuned to their unique challenges will be appropriately posed to work in tandem with youth to develop a safe and appropriate healthcare plan, tailored to their distinct needs depending on their stage in the cycle of exploitation. Partnering with CSEY in order to develop tailored interventions would be particularly helpful during instances where youth are actively trafficked and experience little perceived autonomy over their reproductive health decisions.

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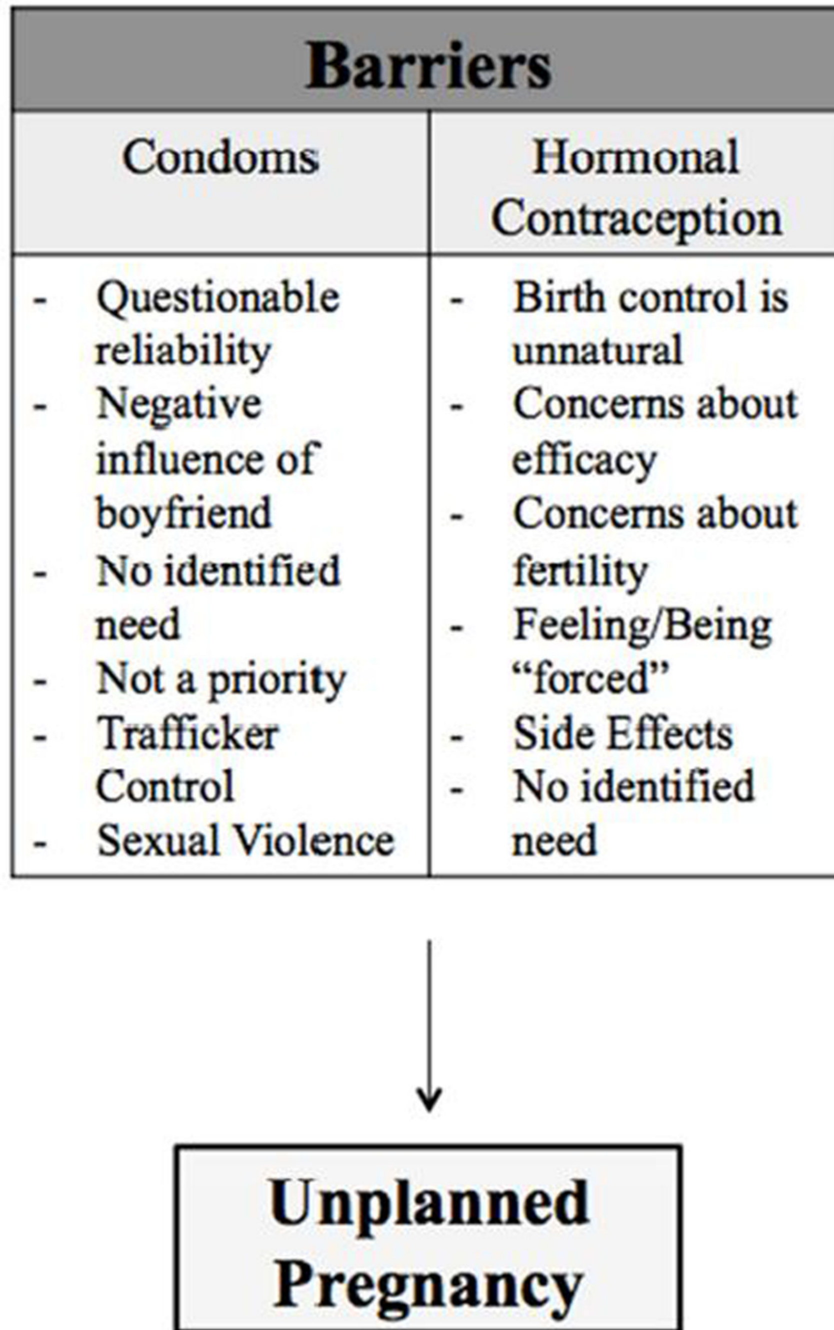

Figure 1.
"If it Happens, it Happens" Hormonal Contraception and Condom Use Barriers Related to CSEY Unplanned Pregnancy

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Table 1.

Representative Quotes from CSEY on Facilitators and Barriers Towards Condom Use

FACILITATORS	
Facilitator	**Participant Quote**
Personal Preference for Condom Use	"Use condoms-- that's the only way or to not do it at all."
	"I have a boyfriend and there's times where we [have sex], but I'm cautious and make sure I keep myself protected. Other than that I feel like I'm okay and don't need birth control"
	"I prefer condoms; but lately, well, I only stuck to one person. But before that person I would just use condoms whenever I had sex with someone"
	"I prefer condoms; which I don't even use, but condoms."
Sexual Health Education at School	"I wore condoms every time. I learned through classes in high school and middle school about protection and stuff."
Sexual Health Education with Medical Provider	"My doctor explained to me the about the different types of condoms like female and male. It helped. It made a big difference."
BARRIERS	
Barrier	**Participant Quote**
Questionable Reliability	"I try to use condoms and stuff like that but sometimes it pops"
Negative Influence of Boyfriend	"I'm pregnant right now; and my baby's father doesn't like using [condoms] when we're having sex. If I know we're not cheating on each other, then we won't use [condoms]. But if I know we are cheating on each other, then yes."
No Identified Need	**Perceived Monogamy**
	"I'd been with this person for two years so I didn't think to use a condom cause I trusted him or whatever."
	Perceived inability to become pregnant
	"When I was with my boyfriend for a whole year we didn't use condoms or nothing or no birth control and I didn't get pregnant."
	Perceived ability to prevent pregnancy and sexually transmitted infections without condoms
	"I didn't need condoms or birth control. I was extra protective over what was going on and made sure I would shower and stuff."
	Abstinence
	"I don't need [condoms]. I don't need to have sex right now. I'm not even at that age, and I don't want to."
Not a Priority	"I had STD's in [the life] and stuff because of condoms popping or not noticing."
Trafficker Control	"At that point in time, I didn't really have a choice [to use condoms]."
Sexual Violence	"This trick raped me. He wouldn't be nice enough to use a condom."

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Table 2.

Representative Quotes from CSEY on Facilitators and Barriers Towards Hormonal Contraception

FACILITATORS	
Facilitator	**Participant Quote**
Not Having a Period	"I heard a lot of stories like sometimes [birth control] doesn't work for some people, but it's been really good to me. I don't get a period. It works, it's really helpful"
Appreciation of Long-Acting Reversible Contraceptive Methods	"The implant is 3 years, and I don't always have to wake up at the same time and then take the pill at the same time. I won't have to worry about this."
Confidence in Birth Control Method	"They said they've tried this one on several different people and it works. So I just went with this one, because it was the strongest one."
Communal Support	"I started birth control when I was 14, 15. I started with my parents…"
	"I told my social worker and everybody and we all agreed that I go on birth control."
Autonomy	"I chose to get birth control. I chose to get condoms. I chose to get checked out. At the adolescent clinic, it's actually easy, and you don't need a parent."
BARRIERS	
Barrier	**Participant Quote**
Birth Control is Unnatural	"I don't know what to get, because it all just seems so unnatural."
	"I don't want nothing going in my vagina. To just sit there; I don't want nothing plastic in there. So I don't know about anything going in there."
	"I don't trust anything inside my body"
	"The patch; the ring; I've heard everything. So, I just don't like anything being inserted into me."
Concerns About Efficacy	"When I found out that there's still a chance of people getting pregnant with [birth control], I felt like there's no point— if something happens then you're going to have to deal with the consequences"
	"I've seen a lot of stories where people got pregnant on birth control."
Concerns About Fertility	"I don't like the thought of birth control. I think it's going to mess up when I want to have a kid, like it's going to mess up my count or something"
	"I never took birth control or never got any of the shots that stop you from having babies. Some people say birth control prevents you from having babies in the future."
Feeling "Forced"	"They always be like forcing you, pushing you to get it. It'd be like a must. Every time I go they're all birth control, birth control, birth control."
	"They gave me birth control without telling me, they did the shot. Without me signing consent or anything. I'm like what the fuck. I wasn't okay with that."
	"I don't take birth control. I don't. I won't and I never will"
Side Effects	**Irregular Bleeding**
	"It stops your period and I think that's kind of weird. Like, taking the pill to stop your period, it's not normal to me"
	"To be honest I don't do birth control. I don't do no birth control, it all messes with your body, it messes with your period, in general"
	"[The pill] messed up my period, it just kept coming, every day."
	"I took birth control before but it just really messed me up. My cycles are bad and it just made it worse. I just told myself I would never take birth control again, cause I got my period for a whole month."
	Weight Gain
	"The shot makes you fat. I don't want to gain weight. I have problems with my weight."
	"The pill, the shot, make you fat. I don't want to gain any more weight…I'm already big, so I don't actually think about what birth control I want."
	"Birth control makes you fat"
	"The shot made me gain a lot of weight. I gained 30 pounds, 3 weeks after I had it."
	Peer Accounts

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	"I have friends that were on different types of birth control and they all had bad experiences with it. So I was just like, no [birth control]."
	"I'm just going based off what rumors are saying; what people are saying; and not based off what a professional is saying."
	"I've seen people talk about birth control messing up their body. Just weird stuff. I'm just like I'm cool. I'm good."
No Identified Need	"I don't feel the need to be on birth control right now because I don't see anybody."
	"After I have my kid I might plan on getting [birth control]. I'm thinking about just not having sex."

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Table 3.

Representative Quotes from CSEY on Reproductive Health Recommendations

Recommendation	Participant Quote(s)
Provide additional sexual health Education	"I want more information about STI prevention about how it could happen. With me, I was scared. I didn't know whether I did catch HIV or anything. If I would still be able to breast-feed him. I feel like information like that should be given out."
	"I think there should be more classes that tell you about sex. I don't think there's really any classes like that. Maybe in certain schools, but not the schools I go to."
	"I want information about having babies or STD's. Because they don't tell you information till after you're pregnant or after you get it. So I think more information before it happens."
Increase social media outreach to provide additional sexual health education and increase awareness of services available	"Social media outreach would be something big; because now everyone's kind of obsessed with their phones."
	"A phone line could probably be useful for a woman to just be able to call and find the nearest resources."
Increase advertising of available reproductive health services on the street	"There needs to be more advertisements on the street like showing that you can take the 72 before, or something like that."
Provide basic necessities in the medical setting	"It'd be great if there was a place that I could go and get necessities for free. Tampons, condoms, and free stuff…Because I didn't have a place to stay. I would stay at someone's house every day, a different house. I had to be there when he told me to and I never had my own money. You can't walk around with blood running down your legs."
Lower the cost of reproductive health supplies	"Lower the price on pregnancy tests and your ovulation tests. Because those are really expensive. They're like $17 for this little test."