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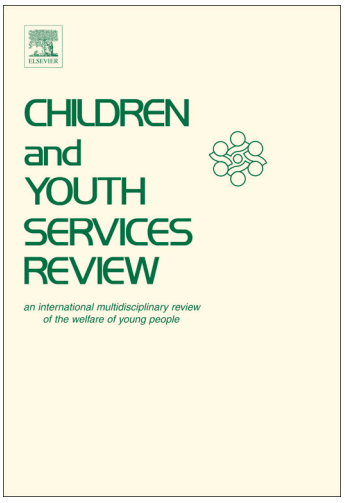

A Roadmap to Enhancing Community Based Participatory Research Strategies and Collaborative Efforts with Populations Impacted by Commercial Sexual Exploitation

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Abstract

We integrated core community based participatory research (CBPR) principles in an intervention research study that aimed to address the sexual health needs of system-involved youth with histories of commercial sexual exploitation (CSE). Researchers, multidisciplinary stakeholders, and individuals with lived experience built upon each other's strengths and resources to adapt an evidenced-based reproductive health curriculum and develop an innovative sexual health intervention. This article presents key findings and recommendations that researchers can implement prior to, during, and after engaging individuals with lived experience and multidisciplinary stakeholders to support a prosperous bi-directional relationship. It is imperative that all collaborators recognize the value of lived experience and create a culture that encourages contributions beyond one's history of exploitation. Conducting an assessment to ensure individuals with lived experience feel mentally and emotionally prepared to participate may help reduce the potential for re-traumatization. Given the dearth of available health-related interventions for this population and strategies to guide collaboration, our findings may inform future efforts aimed at reducing health disparities, promoting equity, and improving sexual health outcomes amongst this population.

Keywords: Adolescent health; community-led change; child sex trafficking; commercial sexual exploitation; domestic minor sex trafficking; intervention research; reproductive health and rights; sexual health

A Roadmap to Enhancing Community Based Participatory Research Strategies and Collaborative Efforts with Populations Impacted by Commercial Sexual Exploitation

1. Introduction

Integrating community members in health-related intervention research is a well-documented strategy used within health promotion domains (Chiu, 2008; Salimi et al., 2012). In particular, participatory research approaches, such as community-based participatory research (CBPR) promote health equity by partnering with community members around their self-identified health needs and goals—a principle shown to bolster health programming efforts within marginalized communities (Hills & Mullet, 2000; Kreuter et al., 2012; Macaulay, 2017; Minkler, 2005; Salimi et al., 2012; Wallerstein, 2017). This strategy may be especially beneficial for individuals impacted by commercial sexual exploitation (CSE), given their elevated burden of sexual health concerns and salient gaps in reproductive health education and interventions (Kelly et al., 2018; Le et al., 2018; Macias-Konstantopoulos et al., 2015).

Research has found that CSE leads to myriad negative sexual health outcomes, such as sexually transmitted infections (STIs), HIV/AIDS, unplanned pregnancies, miscarriages, and unsafe abortions (Barnert et al., 2020a; Le et al., 2018; Macias-Konstantopoulos et al., 2015).Yet, the sexual health needs of CSE-impacted youth are often overlooked (Kelly et al., 2018; Le et al., 2018). While few research studies have documented the use of CBPR approaches and methodologies to engage individuals with CSE lived experience, it has been shown to offer promising benefits, such as greater autonomy and decision-making power (Carranza et al., 2013; Dhungel et al., 2019; Lockyer & Koenig, 2020; Thompson et al., 2019; Wachter et al., 2016).

CSE, also known as child sex trafficking, is a sexual rights violation that is destructive to the reproductive health and wellbeing of youth. The term CSE of children is widely used and encompasses a range of sexual crimes committed against minors below the age of majority in

exchange for anything of value (IOM & NRC, 2013). These youth often perform sexual acts, such as transactional sex or pornography, in exchange for money or anything of perceived value, such as food and housing (IOM & NRC, 2013). Notably, individuals with marginalized identities, such as Black and Latinx girls as well as youth in the LGBTQ+ community, are most vulnerable to sexual exploitation (Butler, 2015; Williamson & Flood, 2021; Xian et al., 2017). These populations also experience disparate health treatment and inequitable reproductive health outcomes (Hammond et al., 2020; Prather et al., 2018). Therefore, achieving health equity requires a continuum of sexual and reproductive health interventions that are culturally appropriate and responsive to the specific needs of this population (Macy & Johns, 2011; Prather et al., 2018).

1.1. Overview of CSE in the United States

The scope and prevalence of CSE remains largely under-investigated and, therefore, undetermined (Franchino-Olsen et al., 2020). Still, many studies have described the predisposing risks for CSE and the implications for youths' health and wellbeing (Barnert et al., 2019b; Bath et al., 2020; Le et al., 2018). Vulnerabilities to CSE include experiences of childhood emotional and sexual abuse, rape, as well as a minority racial, ethnic, sexual, and/or gender identity (Atteberry-Ash et al., 2020; Franchino-Olsen, 2021; Hampton & Lieggi, 2020; Reid et al., 2017; Williamson & Flood, 2021). Additional factors that increase youths' risk of CSE include histories of poverty, houselessness, and involvement in the child welfare and juvenile justice systems (Atteberry-Ash et al., 2020; Bath et al., 2020; Fedina et al., 2019; Hammond et al., 2020; Reid et al., 2017).

Sexual victimization is often experienced along a continuum, beginning with childhood sexual abuse, and continued during their exploitation (De Vries & Goggin, 2020; Fedina et al., 2019; Reid et al., 2017). Childhood sexual abuse negatively impacts one's self-image, social

functioning, and contributes to sexual desensitization, resulting in difficulty navigating interpersonal relationships and setting healthy boundaries in adolescence and young adulthood (Bounds et al., 2015; IOM & NRC, 2013; Kramer, & Berg, 2003; Lalor, & McElvaney, 2010; Landers et al., 2020; Purtscher, 2008). CSE also results in high rates of depression, post-traumatic stress disorder, shame, social anxiety, suicidality, and self-medication with substances (Bacharach et al., 2020; Barnert et al., 2020a; Bath et al., 2020; Laird et al., 2020). Lastly, these youth often endure multiple forms of sexual violence, such as sexual assault, gang rape, and forced unprotected sex, which results in costly and long-term physical and sexual health concerns (Cole et al., 2016; Hampton & Lieggi, 2020; Ravi et al., 2017).

1.2. CSE, system-involvement, and sexual health outcomes

Child welfare and juvenile justice involvement are among the most common risk factors for CSE (Franchino-Olsen, 2020). Youth in these systems, including those experiencing CSE, have a myriad of sexual health behaviors and outcomes. Prior research has found that youth in foster care have higher rates of early sexual initiation, unprotected sexual behaviors, multiple sexual partners, STIs, and pregnancy and parenting than the national average (Ahrens et al., 2013; Boustani et al., 2017; Combs et al., 2018, Dworsky, 2018; Griffin et al., 2021; Finigan-Carr et al., 2018; Winter et al., 2016). Girls in foster care are also at heightened risk of becoming pregnant multiple times (Hamilton & Ventura, 2012; John Burton Advocates for Youth, 2018; Putnam-Hornstein et al., 2013). Similarly, youth in the juvenile justice system frequently engage in precarious sexual behaviors, such as inconsistent condom use, having multiple sexual partners, and engaging in sexual intercourse while under the influence, which has resulted in higher rates of STIs compared to peers in the general population (Barnert et al., 2020b; Borschmann et al., 2020; Finigan-Carr et al., 2018; Griffin et al., 2021; Udell & Mohammed, 2018). One study found that among girls ($N = 360$) with histories of CSE in the juvenile justice system, almost

one-third (31%) experienced at least one pregnancy, of which about 17% reported two or more pregnancies (Barnert et al., 2020a). The youngest age of first pregnancy was 12 years old and the average age was 16 years old (Barnert et al., 2020a). Additional health outcomes linked to CSE include elevated rates of STIs, including HIV, miscarriages, forced abortions, and challenges with intimacy and interpersonal relationships (Barnert et al., 2020a; Hampton & Lieggi, 2020; Hornor & Sherfield, 2018; Kelly et al., 2018; Le et al., 2018).

Despite these sexual and reproductive health outcomes, gaps in reproductive and sexual health education, treatment, and support remain (Aparicio et al., 2015; Borschmann et al., 2020; Kelly et al., 2018; Kuhns et al., 2021; Le et al., 2018). Gaps in knowledge have been particularly harmful to pregnancy and STI prevention, as youths' misconceptions about hormonal contraception have shown to impact behaviors such as inconsistent use (Kelly et al., 2018). Targeting youths' knowledge, attitudes, and beliefs about contraception may improve their beliefs about contraceptive efficacy and consistency of use (Finigan-Carr et al., 2018; Guzzo & Hayford, 2018). Further, research suggests that comprehensive sex education in adolescence may improve reproductive health behavior throughout the life course (Guzzo & Hayford, 2018). In short, system-involved youth have high reproductive and sexual health needs that may be improved through targeted and comprehensive prevention and intervention efforts (Aparicio et al., 2015; Aparicio et al., 2021; Borschmann et al., 2020; Kuhns et al., 2021).

1.3. Youths' engagement in health services and need for culturally relevant interventions

While CSE-impacted youths' access to reproductive health services is relatively high, their engagement in treatment remains complex and fragmented (Barnert et al., 2019a; Goldberg et al., 2017; Greeson et al., 2019; Wallace et al., 2021). Prior research has documented these youths' negative provider experiences, including the perception that providers are exhausted, stressed, and irritated (Wallace et al., 2021). Youth have also reported feeling judged,

stigmatized, or not taken seriously which has led to their disengagement in health-related services, even in cases requiring emergency care (Albright et al., 2020; Barnert et al., 2019a; Godoy et al., 2020; Ijadi-Maghsoodi et al., 2016). Though there is a need for sexual health treatment and programing, there are only two sexual health education curricula developed specifically for system-involved youth: Making Proud Choices for Youth in Out-of-Home-Care (Jemmott et al., 1998; Jemmott et al., 2016) and Power Through Choices (Oman et al., 2016; Oman et al., 2018). There are currently no specialized sexual health interventions specific to system-involved youth impacted by CSE that we know of.

Prior studies have documented the key characteristics that are effective in specialized reproductive and sexual health programming and interventions for system-involved youth (Aparicio et al., 2021; Finigan-Carr et al., 2021; King et al., 2019; Kuhns et al., 2021). Research indicates that system-involved youth require education and services that are consistent, responsive, and high-quality—especially amidst frequent changes in housing placement (King et al., 2019). Moreover, comprehensive sexual health education should address safe sex practices, the effectiveness of condom use in STI and pregnancy prevention, pregnancy options (e.g., live birth, abortion), and the unique vulnerabilities associated with system-involvement, such as histories of abuse and the lack of agency in sexual health decision-making (Aparicio et al., 2021; Finigan-Carr et al., 2021; Oman et al., 2018; Zhao et al., 2017). In addition, Aparicio and colleagues (2021) suggest that system-involved youth require sexual education that is focused on youths' wellbeing, grounded in lived experience, and addresses the interaction between trauma, mental health, and substance use. Other key strategies include providing information on healthy relationships, opportunities to connect with supportive peers, adults, and nonjudgmental service providers, and psychoeducation that is positive, affirming, and education focused (Aparicio et al., 2021; Kuhn et al., 2021).

Similarly, system-involved youth impacted by CSE have expressed a strong desire for clear communication, autonomy over decisions affecting their health, and opportunities to develop trusted relationships in a non-judgmental and caring environment (Barnert et al., 2019a; Barnert et al., 2019b; Godoy et al., 2020; Ijadi-Maghsoodi et al., 2018; Ijadi-Maghsoodi et al., 2016). The *Fierce Autonomy* conceptual model underscores the need for intervention strategies to center youths' self-determination, perceptions, and preferences while also being culturally relevant and appropriate (Barnert et al., 2019a; Godoy et al., 2020). These characteristics might be especially useful, given that CSE-impacted youth historically lacked control over decisions related to their bodies and health (Barnert et al., 2019a; Godoy et al., 2020). Upholding youths' preferences, such as learning from adults with lived experience, may also increase their engagement in healthcare services (Bath et al., 2021; Kelly et al., 2018). Still, a review of available specialized programs revealed limited data on their implementation and effectiveness with little information available on reach, adoption, and maintenance of respective programs (Felner & DuBois, 2017).

1.4. Benefits of CBPR with the focal population

There are limited studies using CBPR or participatory research methods to address the needs of this population. One article reviewed the community-cultural strategies used to develop a strength-based program to prevent CSE in the Solomon Islands (Thompson et al., 2019). This study prioritized the voices and engagement of Indigenous facilitators and highlighted the importance of in-group social support in guarding youth from sexual exploitation and abuse (Thompson et al., 2019). Other studies using CBPR with adult women formerly involved in commercial sexual activity underscored key considerations, such as ensuring bi-directional learning, evaluating racial privilege, and coalition dynamics (Gerassi et al., 2019; Gow et al., 2015; Sarkis, 2017). CBPR has also demonstrated efficacy in creating healing spaces for people

with histories of sexual abuse and/or intimate partner violence (Gerassi et al., 2017; Ragavan et al., 2020; Ratcliff et al., 2018), as well as coalition-building among women who trade sex as an essential foreground (Gerassi et al., 2019). Still, there remains a significant gap in the literature surrounding the use of CBPR in programmatic undertakings for youth impacted by CSE, and to our knowledge, none related to sexual and reproductive health specifically.

Still, available research suggests that CBPR is a useful mechanism for centering the perspectives of individuals with CSE lived experience while generating rich and nuanced data (Lockyer & Koenig, 2020). CBPR can rectify power imbalances between the researcher and participant and promote a sense of empowerment by affording participants' agency over decisions related to designing and implementing interventions intended to support them (Carranza et al., 2013; Lockyer & Koenig, 2020). In addition, CBPR has been shown to improve self-competence and self-esteem by encouraging individuals with lived experience to reflect on how their strengths and abilities contribute to their resilience (Carranza et al., 2013; Lockyer & Koenig, 2020). Therefore, integrating principles of CBPR to identify and address sexual and reproductive health-related recommendations was central to this research study.

1.5. The present study

To address a critical gap in reproductive health education, we integrated core principles of CBPR during the development of a sexual health intervention for youth affected by CSE. CBPR principles, such as recognizing and building on the community's strengths and facilitating an equitable and collaborative partnership (Israel et al., 1998), guided our collaboration with individuals impacted by CSE and the multidisciplinary stakeholders who support. The overall research goal was to partner with individuals with CSE lived experience and multidisciplinary stakeholders to inform: (1) the identification and adaptation of an evidence-based sexual health

curriculum; and (2) the development of a larger sexual health intervention for CSE-impacted youth in the child welfare and juvenile justice systems. To that end, we developed a sexual health intervention entitled *My Body My Choice* which combines an adapted evidence-based curriculum with mobile health (mHealth) technology.

The focus of this article is to describe the lessons we learned from implementing a CBPR approach while engaging youth impacted by CSE, lived experience experts, and multidisciplinary stakeholders in research activities. Based on these experiences, we outline key recommendations to enhance future CBPR engagement strategies and collaboration with the focal population. We also share key adaptations made to the original sexual health curriculum during the collaborative process. Throughout this article we use the term "youth" to describe any young person who has experienced CSE, unless otherwise specified.

2. Materials and methods

2.1. Selecting an evidence-based, reproductive health curriculum to adapt

Using a CBPR approach, we developed My Body My Choice—a comprehensive sexual and reproductive health intervention that addresses the specific needs of system-involved youth with histories of CSE. To identify an appropriate sexual health curriculum to adapt for My Body My Choice we consulted with reproductive health experts, including the Los Angeles Reproductive Health Equity Project for Foster Youth, and reviewed findings from a pilot study involving youth in foster care without histories of exploitation (John Burton Advocates for Youth, 2018). To that end, we identified the evidence-based, reproductive health curriculum entitled, "Making Proud Choices! An Adaptation for Youth in Out of Home Youth 5th Edition" (MPC; Jemmott et al., 2016).

The MPC curriculum is adapted from a skills based STI/HIV intervention that is uniquely designed to improve the reproductive health outcomes among youth in the foster care system.

Studies examining the efficacy of the original skills based STI/HIV intervention found that Black youth and Latinx girls in low-income, under-resourced settings benefited from the intervention (Jemmott et al., 1998; Jemmott et al., 2005). In particular, the intervention increased condom use, decreased the number of sexual partners, and decreased testing positive for an STI (Jemmott et al., 1998; Jemmott et al., 2005). Given these findings coupled with the adaptations for youth in foster care, we deemed MPC a culturally appropriate curriculum to modify for the development of My Body My Choice.

2.2. Community-based participatory research (CBPR) as a guiding framework

CBPR is a research paradigm grounded in social action and critical consciousness theories, both of which underscore the role of participatory research in mediating community change across multiple levels of influence (Salimi et al., 2012). CBPR posits that shared power and decision-making is instrumental in producing collective action within communities (Wallerstein, 2017). In reaction to the traditional "evidence-based" praxis of academic-community research that is conducted on and/or for marginalized communities, CBPR presents eight core principles for praxis (Israel et al., 1998; Israel et al., 2010; Wallerstein, 2017). The CBPR core principles include: (1) recognizing community as a unit of identity; (2) identifying and building on the community's strengths and resources; (3) facilitating collaborative partnerships throughout the entirety of the research study; (4) building knowledge to inform action with the intention that all partners benefit; (5) promoting an empowering and co-learning process that attends to social inequities; (6) using a cyclical and iterative process; (7) addressing health from both positive and ecological perspectives; and (8) disseminating findings and knowledge gained among all partners (Israel et al., 1998; Israel et al., 2010).

2.3. Identifying collaborative partners

The research team purposely employed a collaborative, multidisciplinary approach to engage stakeholders from county and community based agencies as well as lived experience experts. We identified key stakeholders at the administrative level, supervisory level, and on the frontlines that specialized in providing services to youth affected by CSE or reproductive health interventions. The multidisciplinary stakeholders were part of a local healthcare provider, multiple community based advocacy agencies, and the Los Angeles County Departments of Public Health, Children and Family Services, Probation.

Lived experience experts is a term that was developed and defined by these partners as individuals with prior histories of CSE and experience providing mentorship to youth with similar backgrounds. The lived experience experts identified as cisgender females in their twenties and thirties, predominately of Black and African American identities, and had extensive experience mentoring youth with CSE histories. In partnership with a community based agency, we developed a youth advisory board comprised of young people between the ages of 18 and 20 with prior histories of CSE and system-involvement. The community based agency acted as a gatekeeper and provided access to the population.

Purposive sampling used to identify potential collaborative partners, specifically convenience and snowball sampling techniques. First, convenience sampling was used to identify potential collaborators based on the research team's prior experience with and knowledge of county and community based agencies serving the focal population. Second, snowball sampling enabled stakeholders and lived experience experts to identify other potential participants. The research team set eligibility criteria for potential participants based on the following: (a) experience providing direct services to youth at risk or with histories of CSE; (b) experience at the administrative or supervisor level in an agency that provides CSE-related services to youth; (c) experience facilitating reproductive and sexual health interventions with

youth at risk or with confirmed histories of CSE; or (d) experience receiving CSE-related services from a partner agency.

2.4. The engagement timeline and process

The research team held nine meetings with a total of 26 multidisciplinary stakeholders and seven lived experience experts between June 2019 and October 2020. In these meetings we identified facilitators and barriers to sexual health education and feasibility and acceptability of developing the sexual health intervention for this population. We also discussed discrete components of the intervention, elicited feedback, and made revisions in real time or gathered information to inform suggested changes. At a high level, meetings with the multidisciplinary stakeholders and lived experience experts helped ensure that the intervention was at a minimum medically accurate, trauma-informed, and person-centered.

Youth advisory group members participated in a total of six meetings between July 2020 to October 2020. Each meeting included between four and seven youth, and were separate from meetings with lived experience experts or multidisciplinary stakeholders. During these meetings, youth participated in specific activities, allowing them to share their perceptions of suitability and perspectives on all aspects of the intervention. Within these meetings we discussed and revised to ensure the intervention included age appropriate and youth friendly language, tested the feasibility of Internet-based group activities, revised the visual aesthetics of the curriculum, and examined the overall content and acceptability of the intervention. Due to COVID-19 pandemic social distancing restrictions, all meetings with the youth advisory board took place via a secure, online video conferencing platform. Meetings with the youth advisory board were audio recorded, transcribed, and checked for accuracy by research team members.

Field notes were written during and immediately following meetings with collaborators to capture verbatim quotes and contextual information. Formal meetings were supplemented by

regular, close, and ongoing consultation via telephone, text message, and email between the research team, multidisciplinary stakeholders, lived experience experts, and youth advisory board members.

2.5. Reflecting on the CBPR process

Our suggestions for enhancing CBPR approaches were informed by the experience of the research team, a lived experience expert, and a multidisciplinary stakeholder involved in the development of My Body My Choice. Together, as co-authors, we held several team meetings to reflect on the collaborative process and identify practices that may guide researchers and practitioners in working with live experience experts to increase equity and health-related outcomes. In addition, transcriptions and field notes were organized and reviewed by two research team members to identify relevant ideas, suggestions, and themes. The suggestions presented in this article were developed in an iterative and cyclical manner, and disagreements were resolved within team meetings.

3. Results

3.1. Overview of findings

Engaging CSE-impacted youth, lived experience experts, and multidisciplinary stakeholders is an iterative process that requires ongoing relationship building and support, among other strategies. We identified key strategies that researchers can implement prior to, during, and after engaging individuals with CSE lived experience and multidisciplinary stakeholders in research activities which focus on supporting a prosperous bi-directional relationship. These suggestions are based on the coauthors experiences of developing My Body My Choice in a collaborative process, and are intended to guide researchers using CBPR approaches with the focal population.

3.1.1. Prior to engagement in research activities

Prior to engaging individuals with CSE lived experience in research activities, we suggest that researchers conduct a brief assessment to determine if potential participants feel mentally and emotionally prepared to engage in activities. Given that these youth often have extensive histories of trauma and lacked agency in decision-making, a brief assessment should be part of the initial recruitment phase. Using the Stages of Change model may be beneficial. When assessing if youth feel able to participate in activities, such as a youth advisory board, it may be necessary to partner with a lived experience expert or multidisciplinary stakeholder that has an established relationship with the young person. This collaborator, who may also be a gatekeeper to the focal population, can support or conduct an assessment to help provide: (1) an accurate depiction of the youths' recovery process after the exploitation; and (2) emotional support prior to, during, and after the youths' engagement. These efforts can help avoid re-traumatization by ensuring that the individual feels prepared to discuss sensitive topics related to CSE and have the necessary support while engaged in research activities. In addition, incentivize the collaborator supporting the youths' assessment appropriately.

Cultivating a culture where all collaborators feel inspired to co-create shared goals, expectations, and deliverables prior to engaging in research activities is crucial. All expectations and any salient information should be clearly documented and made easily accessible in a secure, online platform. Having this information memorialized and easily accessible will allow collaborators to plan ahead, develop a structure that works for them, and encourages a sense of ownership over the project. In addition, researchers should be clear about project details and how prior experiences of CSE help shape the overall research study and collaborative process. These details may impact how collaborators understand the research study and their role while ensuring they feel valued, rather than re-exploited for research purposes. Researchers can also provide a

brief background on the type of research being conducted (e.g., pilot study; intervention research) and the implications to mitigate confusion about the overall intentions of the study. Sharing relevant information, such as the number of collaborators, and other logistics, such as transportation, will ensure there is full transparency and mitigate any potential mistrust.

Assess collaborators level of commitment to the research study, ensuring they have the desire to be involved and awareness of the time commitment. Given that research activities may be slow moving it is critical that researchers are transparent about the estimated timeline and potential roadblocks, so that individuals with lived experience do not feel their time is not being respected. Inquire about other obligations that may impede upon their attendance or ability to complete agreed upon activities and deliverables. Ensure all collaborators are appropriately incentivized for their time through fair remuneration and other means to avoid re-exploitation. The monetary amount should be standardized and agreed upon, and the strategy to dissemination should be clear and timely. Non-monetary benefits, such as professional development opportunities, should be made clear.

Develop a communication strategy that works for everyone. Collaborators will likely have numerous competing demands, such as school, work, and family, that require time and attention. Using several modes of communication, such as email, individual text messages, group text messages, and phone calls, may be especially useful to ensuring communication is clear and consistent. Of importance, avoid using group chats with collaborators, including youth, who are unfamiliar to each other (e.g., a new lived experience expert not formally introduced). This will ensure that no personal identifiable information is shared and may reduce adverse outcomes, such as bullying or peer-to-peer recruitment into commercial sexual exploitation.

3.1.2. During engagement in research activities

To develop an environment where all collaborators feel safe to discuss difficult topics, such as abuse and exploitation, it is critical to identify a core team, which includes researchers, individuals with lived experience, and multidisciplinary stakeholders, and maintain consistent communication. Maintaining continuity with collaborators will assist in minimizing disruptions to group integrity and help build trust. When collaborators change it can be difficult to build rapport, especially if research activities are well underway. Ensure that ample time is given to onboarding new collaborators which includes building trust between collaborators, setting expectations around time commitment, and delineating core duties. One team member can be designated to send reminders using the agreed upon communication strategies (e.g., email, text messages, phone calls) on agreed upon days and times (e.g., one day prior to the meeting). When engaging youth, designating a collaborator to send reminders and notifications of upcoming meetings may be useful in ensuring they respond and attend. The individual designated to send meeting reminders should be highly trusted among the youth. It should be emphasized that the youths' contact information will remain confidential to avoid potential worries that an adult outside of the study (e.g., exploiters) may have access to their information.

Cultivate a safe, non-judgmental, and affirming space that encourages rapport building and creativity. This also enables collaborators to cultivate meaningful relationships, which will ultimately enable trust and candid feedback throughout the research process. Though meetings may be driven by specific agenda items, designate time within meetings for informal discussions and dialogue to build team cohesion. For example, demarcate time the initial 30 minutes of the meeting to socialize and an additional 30 minutes following the meeting to process their experiences. Setting a timer may help designate time limits that are specific and clear. Discussing issues indirectly related to the research affords space for intimate and casual conversations that

may ultimately influence how much information individuals with CSE lived experience are willing to divulge to others. This requires meeting the collaborators where they were, allowing flexible timelines, and making space for information to organically emerge. Finally, cultivating relationships helps collaborators identify and respond to any emergent adverse experiences, such as trauma responses to research related content or activities. If collaborators experience trauma reminders, ensure there is space to support them through this process and connect them to resources as needed.

Create a culture that encourages collaborators to share agency over decisions that impact all facets of the collaboration and project. Recognize the value of lived experience while also understanding that individuals with CSE lived experience are whole people capable of making contributions beyond providing perspectives related to their histories of exploitation. Explore other opportunities to engage and support these individuals. For instance, individuals with lived experience may have experience in graphic design, data analytics, or building and facilitating curricula. Explore opportunities for individuals with lived experience to contribute in manners that go beyond their experiences of exploitation.

Be mindful of timelines and additional obligations of collaborators. Agreeing upon a structured timeline with designated meeting times and dates (e.g., meetings twice a month) may reduce attrition. While meeting dates, times, and locations should be consistent, flexibility is crucial. Notably, requesting too many meetings within a short-time frame may become burdensome or overwhelming, especially for youth healing from extensive histories of trauma. On the other hand, holding meetings too infrequently or very far apart may lead to inconsistent attendance and difficulty maintaining rapport, ultimately impacting professional relationships and overarching goals. Youth with histories of CSE are known to run away or disconnect from

treatment. Therefore, it is likely that CSE-impacted youth may not attend all scheduled meetings. It is important that researchers and other collaborators use a strategy that keeps these youth accountable while also recognizing that these patterns may be reflective of prior trauma.

Attention should be paid to research settings and information provided at meetings. Trauma-informed settings that only include a small number of collaborators are ideal, especially when discussing sensitive material and CSE lived experience. There should be enough physical space for individuals to comfortably sit or stand to ensure collaborators do not feel overwhelmed in the space or in too close of proximity to others. The meeting location should remain private and safe to ensure that all share information remains confidential. Avoid highly technical language that may create barriers to bi-directional learning and co-creation. Research methods should be explained in a manner that encourages participation. Researchers should provide materials, such as an agenda and slide decks, that clearly delineate what to expect per meeting and overall. Rather than only engaging in dialogue, relevant information that is clearly documented on paper or through visualizations will better prepare collaborators to engage in activities at each meeting.

3.1.3. After engagement in research activities

Researchers should make every effort to sustain ongoing relationships with collaborators and connect collaborative partners to other opportunities. The CBPR framework necessitates continuous collaboration from research design to dissemination of findings, including channels relevant to the community. As such, inviting collaborative partners to co-author publications, co-facilitate presentations, and opportunities to act as representatives among policymakers is important as these activities reflect the currency of the academic landscape for which they should also benefit. Given that individuals impacted by CSE historically lacked control in decisions,

providing agency over how and where research is disseminated may provide a sense of empowerment. In addition, find other ways to support collaborators, such as reviewing resumes, writing letters of recommendations, and making connections with colleagues for other opportunities that leverage the researchers' privileged positionality in ways that facilitate power sharing.

3.2. Additional findings related to the youth advisory board

Youth advisory boards may be effective in centering the voices of youth, as such we identified salient recommendations to bolster future efforts aimed at engaging youth. Table 1 provides an overview of the emergent themes from the youth advisory board process, and recommendations on how to collaborate with youth participants more effectively. The successful development of a youth advisory board required one consistently available multidisciplinary stakeholder to help identify potential youth and assist with logistics. This stakeholder had a prior relationship with these youth, as their advocate in a community based agency, and functioned to increase the feasibility of gathering youth, encourage youths' engagement in activities, and acted as overall support in discussing sensitive topic areas. Integrating a collaborative partner in this role provides youth a sense of familiarity and safety while also holding them accountable in a supportive manner. Of importance, researchers cannot be the only authority figures in the room and collaborators cannot outnumber youth. Multidisciplinary stakeholders and lived experience experts can contribute to the space by ensuring that all youths' voices are being heard and taken seriously.

Prior to engaging in research activities, have an honest and open conversation about how the team can support the youth advisory board members' personal and professional development. While working with these youth, employ terminology such as partner, collaborator, and ambassador that speaks to the collaborative nature of the study while also creating further

ownership of the project. Another important consideration is related to schedules and timelines. It is important to schedule consistent meetings that are not too close together (e.g., multiple within one week) or far apart (e.g., once every couple of months). Given their competing demands, general instability while system-involved, and additional circumstances that affect youth long-term participation may not be feasible.

Finally, youth advisory boards may be especially helpful in the implementation of intervention research. Given their role in the development process, incentivizing youth as co-facilitators during implementation may enhance their own confidence and bolster peers' trust in the intervention. Using youth-friendly language, such as the "outreach squad," and techniques that give youth voice related to implementation procedures may also influence their peers to attend and actively participate. In addition to benefitting the quality and impact of the research, participating in a youth advisory board can be helpful to youths' own healing process by creating a space to positively influence and participate in their peers' lives, and serve as a leadership opportunity that can be used to build their resumes and professional development.

3.3. Adaptations to the sexual health curriculum

The collaborative partnership helped ensure the My Body My Choice intervention was relevant, clear, appropriate, and inclusive for all system-involved youth who were at-risk of or had confirmed histories of CSE. Table 2 provides an overview of the differences between the core components of the original MPC curriculum and those of the newly developed My Body My Choice intervention. Several additions to the intervention were based on suggestions made by lived experience experts. For instance, we co-created an activity that educates youth about the financial costs associated with raising children. Another lived experience expert suggested we

incorporate psychoeducation about healthy sexual relationships after sexual exploitation, and highlighted that abstinence is often a critical component in one's healing process.

4. Conclusions

We used a CBPR approach to engage individuals with lived experience and multidisciplinary stakeholders to adapt an evidence-based reproductive health curriculum as part of a sexual health intervention for youth with CSE history involved in the child welfare and juvenile justice systems. The goal of the planned adaptation was to identify differences between the existing curriculum, identify priority reproductive and sexual health problems among the target population, and reconcile these differences. To that end, we refined the intervention in a cyclical and iterative process by identifying salient sexual health needs and incorporating trauma-informed, LGBTQ+, youth-friendly and culturally relevant content. Further, we centered our engagement strategies on the principles of CBPR (Israel et al., 1998; Israel et al., 2010) and aimed to bolster the sexual and reproductive health and rights of adolescents by focusing on equity, quality, accountability, multi-sectorality, and meaningful engagement (Engel et al., 2019). Finally, we identified key strategies for enhancing research collaboration with individuals with lived experience and multidisciplinary stakeholders.

We build upon prior research that suggests that integrating the perspectives of experts with lived experience may resonate with our target population—youth impacted by CSE (Bath et al., 2021). Though data on best practices for serving these youth remains limited, research has found that CSE-impacted youth would benefit from trauma-informed and trauma-specific services, individualized, tailored treatment plans, and interagency collaboration (Hounmenou & O'Grady, 2019). In particular, the CBPR framework enabled the research team to partner with individuals with lived experience and multidisciplinary stakeholders to co-create an intervention intended to meet the specific sexual health needs of system-involved youth.

This article details a roadmap on how to use CBPR and center the perspectives and expertise of individuals with CSE lived experience to work together as collaborative partners in intervention research. The integration of these strategies in sexual health research may bolster engagement, empower a historically disenfranchised group, and disrupt oppressive conditions often unintentionally perpetuated within research. Given the dearth of available interventions for this population or strategies to guide collaboration, our findings may inform future efforts aimed at reducing health disparities, promoting equity, and improving sexual health outcomes amongst this population.

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Table 1. Overview of Emergent Themes and Recommendations from Youth Advisory Board Meetings

Theme	Recommendations
Consistent and clear communication	• Use multiple communication strategies, such as phone calls, text messages, and emails to share relevant information (e.g., meeting reminders) • Elicit youths' preferences on the frequency of communication (e.g., text message twice a week) to avoid overwhelming them with information • Ensure communication is clear and concise, using visual aids (e.g., timelines) when needed
Build rapport and create a comfortable environment	• Create opportunities for all collaborators to develop interpersonal relationships during meetings • Maintain an element of group intimacy and familiarity by limiting group size • Provide ongoing incentives and prizes to encourage all youth to participate and work as a team • Use polling features to reduce pressure of public speaking • Make revisions based on youths' feedback in real time so that youth feel empowered and encouraged during the process • Provide relevant visuals and graphic images to enhance youth engagement
Gauge youths' prior knowledge of content	• Gauge youths' level of familiarity with the meeting content then tailor meeting content with topic areas youth have less familiarity with • Allot ample time to review meeting content and ensure all youth's questions and concerns are answered
Time considerations	• Be mindful of time and provide breaks as needed to avoid fatigue • Youth require multiple reminders of the meeting date(s) and time(s) • If youth arrive late then reduce the disruption to the group flow by having a research team member take the youth into a private setting (e.g., break-out room) to discuss content and troubleshoot
Technological issues	• Prior to meeting, ensure youth have access to a laptop or tablet and access to stable Wi-Fi when participating in a virtual meeting • Review virtual platform features (e.g., mute button, chat function) and ensure all youth's questions and concerns are answered

Table 2. Differences Between Making Proud Choice (MPC) Curriculum and the My Body My Choice (MBMC) Intervention Developed Through the Collaborative Partnership

MPC Curriculum	MBMC Intervention
Abstinence-focused	Harm reduction approach
Built-in prizes and incentives	Prizes and incentives
Efficacious with youth of color	Geared toward racially and ethnically diverse youth
Evidence-based	Evidence-based
Gender normative approach	Sensitive to and inclusive of the LGBTQ community
Interactive, fun	Interactive, fun
Lacking aspects of a trauma-informed framework	Trauma-informed
Medically accurate	Medically accurate
No lens related to CSE	Survivor-centered and led
	Compliant with the California Healthy Youth Act
	Substance Use Psychoeducation

Author Statement

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Highlights

- Researchers should assess emotional readiness of communities with lived experience
- Collaborators must recognize the value of lived experience
- Honor holistic identities beyond prior histories of exploitation
- Incentivize collaborators through fair remuneration and other means