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Commercially Sexually Exploited Young Women's Healthcare Needs, Access, and Utilization Patterns: "Work Around What I Need"

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Abstract

PURPOSE: We sought to understand the perspectives of commercially sexually exploited (CSE) young women regarding their healthcare needs, access, and utilization patterns.

METHODS: Twenty-one CSE young women participated in this mixed-methods study. Data collection included brief surveys measuring healthcare utilization, followed by in-depth, semi-structured interviews to gain insight into CSE young women's healthcare needs, barriers and facilitators to healthcare, utilization patterns, and recommendations for improving care. Data analysis techniques included descriptive statistics for the quantitative survey data and thematic analysis for the qualitative interviews.

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RESULTS: Survey data demonstrated relatively high healthcare utilization across healthcare types, especially for reproductive and mental health treatment services. Barriers to care included *being "on the run," fear of bad diagnoses*, and *trafficker control*. The "Fierce Autonomy" conceptual model emerged from the analyses to describe participants' strong desire for self-determination in their healthcare decision-making, including when to access care. Recommendations for improving care for CSE young women include preserving autonomy in healthcare decisions while meeting their basic needs, such as safety and shelter.

CONCLUSIONS: Overall, the CSE young women expressed high healthcare needs. Despite experiencing significant barriers to accessing care, study participants frequently sought care in a variety of settings. Furthermore, they shared insights about how to improve engagement in healthcare among CSE young women. Improving CSE young women's engagement in care requires health professionals and health systems that foster a sense of safety, trust, and autonomy over healthcare decisions—a need intertwined with CSE young women's experiences of abuse, survival, and sexual exploitation.

INTRODUCTION

In 2000, federal law established that commercially sexually exploited individuals are victims of crime in need of support and specialized services, rather than perpetrators of criminal activity. Federal law defines sex trafficking as inducing commercial sexual activity through force, fraud, or coercion—or when a minor was induced to perform such an act regardless of force, fraud, or coercion ("Trafficking Victims Protection Act of 2000," 2000). Child sex trafficking and commercial sexual exploitation of children are overlapping terms with multiple definitions that encompass various sexual crimes against children and adolescents. These crimes include but are not limited to (i) trafficking for sex, (ii) pornography, (iii) children and adolescents engaging in sexual acts for money or an object or experience of perceived value, and (iv) children and adolescents engaging in "survival sex" to earn money, shelter, or other basic necessities (Institute of Medicine and National Resource Council, 2013). For the purposes of the article, we will use the term "commercial sexual exploitation," except when summarizing other studies. Reliable data on the prevalence of commercial sexual exploitation of children and youth in the U.S. is lacking; however, several known risk factors exist. Risk factors for commercial sexual exploitation include history of abuse, especially childhood sexual abuse; homelessness; substance use; and foster care or juvenile justice involvement (Institute of Medicine and National Resource Council, 2013).

Commercially sexually exploited (CSE) youth may suffer from immediate and long-term adverse health effects including physical injuries, sexually transmitted infections (STIs), unintended pregnancies, post-traumatic stress disorder, anxiety, depression, and suicidality (Barnert et al., 2017; Greenbaum, 2014; Ijadi-Maghsoodi, Cook, Barnert, Gaboian, & Bath, 2016; Ijadi-Maghsoodi, Todd, & Bath, 2014). The health needs of survivors are complex; they often require both immediate care and long-term treatment, such as mental health therapy or medications (Rajaram & Tidball, 2018). A prior study of adult sex trafficked women found that most experienced depression and over 40% had attempted suicide while trafficked (Lederer & Wetzel, 2014). Another study reported that 89% of adult sex trafficked women sustained physical violence, 59% had at least one STI, and 58% became pregnant

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while trafficked (Muftic & Finn, 2013). A study of sex trafficked transition-aged youth (ages 18–25) found that approximately 67% had been physically assaulted and 42% had sustained a life-threatening illness or injury (Ghafoori & Taylor, 2017).

The literature on health and healthcare utilization among CSE children and adolescents indicates that these youth have relatively high mental and physical health needs and interact with healthcare professionals on a relatively frequent basis. A retrospective study of 63 adolescents referred for concerns of commercial sexual exploitation found that most (83%) had received pediatric care at a children's hospital within the prior year. Furthermore, more than half of the adolescents (56%) had at least one prior admission to the children's hospital and several had multiple admissions (Hornor & Sherfield, 2018). Another retrospective cohort study of youth less than 18 years of age referred to a children's hospital for sex trafficking also found that most (81%) had seen a medical provider in the prior year. The most common complaints reported in the prior medical visits were psychiatric issues (28%), abdominal or back pain (13%), and physical injury (9%). Among the sample, 32% had a history of documented STIs and 20% had presented with acute suicidality (Goldberg, Moore, Houck, Kaplan, & Barron, 2017). A related study showed that the majority of CSE youth (75%) had visited a doctor within the prior six months (Curtis, Terry, Dank, Dombrowski, & Khan, 2008). Similarly, Greenbaum et al. (2018) found that among youth presenting to an emergency department who screened positive for commercial sexual exploitation, 35% had seen a health provider within the prior two months. Prevalent health concerns reported in the youths' Review of Systems included vaginal discharge (40%), abnormal bleeding (24%), and pelvic pain (20%).

Prior qualitative research has examined factors that facilitate and inhibit access to healthcare among sex trafficked women and labor trafficked (men and women) survivors. For example, Ravi et al. (2017) identified healthcare access and barriers among 21 sex trafficked women (ages 19–60) involved in the criminal justice system. Salient barriers included fear of retaliation from traffickers, fear of arrest, prioritization of substance use, and lack of financial resources (Ravi, Pfeiffer, Rosner, & Shea, 2017). Additionally, qualitative interviews with stakeholders from service provider agencies identified extensive mental health needs among trafficking survivors. Another study identified limited provider capacity and fragmentation of care delivery as key barriers to the implementation of mental health care for trafficking survivors (Powell, Asbill, Loius, & Stoklosa, 2018). However, data from the adolescent perspective on health care access patterns and preferences remains sparse.

Although CSE youth are known to have increased levels of juvenile justice and child welfare involvement, less is known about factors that influence their access to and utilization of healthcare services. Despite significant health needs, the perspectives of CSE youth regarding their healthcare needs, access, and utilization patterns are notably lacking from the literature. In a prior study, members of our team conducted focus groups with CSE young women to explore their perspectives on health and healthcare access (Ijadi-Maghsoodi, Bath, Cook, Textor, & Barnert, 2017). Participants reported relatively easy access to community health services, despite experiencing several barriers to care related to fear of provider judgment, concerns about confidentiality, and perceived low quality of care. The study provided a broad view of CSE young women's perceived healthcare barriers. However,

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utilization was not measured, the sample was limited to young women residing in group homes, and we were unable to explore several critical but sensitive aspects of healthcare in depth, especially regarding mental and reproductive care (Ijadi-Maghsoodi, Bath, Cook, Textor, & Barnert, 2017). As such, through in-depth, one-on-one interviews, this study seeks to better understand CSE young women's healthcare needs, access, and utilization, and to develop recommendations for improving care from their own perspectives.

METHODS

Design

This study utilized a community-partnered, mixed-methods design. A brief, close-ended survey measured sociodemographic and healthcare utilization data. The surveys guided one-on-one semi-structured interviews, which were conducted to further explore CSE young women's perspectives on healthcare access. The survey instrument and semi-structured interview guide were developed and piloted through an iterative team process. We partnered with a community-based organization that provides services to CSE youth, two residential treatment facilities for child welfare-involved youth (i.e., group homes), and a juvenile court-based diversion program serving CSE youth. All the participants were eligible for services from our community partners because they met those partners' definition of having experienced commercial sexual exploitation. Participants were asked to participate by our community partners, all of whom serve youth in a large urban area in the southwestern United States. The sample included young women residing in the community and in group homes.

Participants

Twenty-one CSE young women participated in the study. Purposive sampling was utilized to identify young women who had been commercially sexually exploited, were between the ages of 13–21, English speaking, and involved with one of the partnering entities during the study period (March – July 2017). None of the young women who were interviewed had participated in the prior focus group study.

Procedures

CSE young women were invited to participate in the study by staff of the partner organizations. Each study enrollment site was purposefully selected based on their high rates of serving CSE youth. The research team was attentive to ensuring that the young women did not feel coerced to participate and to avoiding over-interrogation of the participants (Rothman, Farrell, Bright, & Paruk, 2018). The recruitment and consent procedure occurred as follows. First, the study team provided the community partners the study materials (e.g., recruitment flyer, eligibility screening tool, consent form, data collection instruments). Second, community partners informed potentially eligible young women (i.e., young women ages 13–21, English speaking, and meeting the partner entity's definition of having experienced commercial sexual exploitation) about the study. Third, if individuals indicated potential interest in participating, the partnering agencies informed the study team as to the names and contact information of the young women. Fourth, researchers met with potential participants to describe the study in a private room at the community partner organizations.

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Participants were given an informational packet including youth assent/consent forms; parental consent was waived for minors. The research team emphasized the voluntary and confidential nature of the study, clearly stating that a potential participant's decision to accept or decline participation did not influence their standing with services or the court. Fifth, after obtaining informed consent, a member of the research team administered the two-question eligibility screening instrument. Eligibility was confirmed when a potential participant responded affirmatively that they were: (1) between the ages of 13–21 and (2) had traded sex for something of value.

Young women who consented to participate then completed a brief survey containing multiple-choice, self-report items. The interviewers, all trained in survey administration and qualitative interview techniques, were available to assist participants in answering survey questions. Upon completion of the surveys, participants completed a one-on-one, semi-structured interview. Interviews ranged from 30 to 60 minutes in length and were audio recorded. Participants were compensated for their time with a $25 gift card and refreshments. The University of California, Los Angeles, Human Subject Protection Committee and the county superior court approved all study procedures.

Survey Instrument

The close-ended survey asked about participant age, race, ethnicity, education level, placement history, and housing history. Information was also collected on health services accessed in the prior year, including types of health providers seen and types of health services the young women desired to access. Appendix 1 contains the survey instrument.

Semi-structured Interview Instrument

Responses to survey items regarding utilization guided the open-ended interviews. The semi-structured interview questions explored experiences with physical health, reproductive health, mental health, and substance use treatment within the previous year, including what factors facilitated or hindered access to care. Participants were also asked to provide recommendations for improving healthcare services for CSE young women.

Analyses

Interviews were professionally transcribed with personal identifiers removed from the transcripts and transcripts were checked for accuracy. We used iterative thematic analysis, as described by (Braun & Clarke, 2006). The research team held several group meetings to develop the initial codebook. We used three representative transcripts to create the initial codebook. The three transcripts were coded independently by each member of the study team and then we met as a team to code together and develop a preliminary codebook. The primary coders then applied the preliminary codebook to additional transcripts. At our subsequent meeting, we then refined and reached agreement on the codebook. Once the team reached consensus about the codebook, two study team members coded each interview transcript independently utilizing Dedoose software. We discussed emerging findings at weekly team meetings, which informed the analytic lens of the coders in an iterative fashion. Points of overlap and inconsistency were discussed and refined. When all coding was complete, we came together as a group to organize codes into themes and to develop a

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conceptual model that synthesized the qualitative findings. During this process, the team developed a conceptual model of CSE young women's engagement in care to provide a framework for understanding the observed disconnect between utilization and engagement in care. Approximately 20 interviews were planned; in total, we conducted 21 interviews. Our qualitative analysis of the 21 interviews confirmed that we had reached saturation of themes, which was defined as hearing the same thoughts repeatedly mentioned and not hearing new ideas (Bowen, 2008). To assess the truthfulness of our results, findings were debriefed with our community partners who regularly interact with CSE youth (including survivors of commercial sexual exploitation) and with experts in pediatrics, social work, and child psychiatry who were outside of the study team.

RESULTS

The close-ended surveys and qualitative interviews identified aspects of CSE young women's healthcare needs, access, utilization patterns, and recommendations for improving care. Results are discussed below.

Participant Characteristics (Table 1)

Although eligibility criteria allowed for ages 13–21, the actual participant ages ranged from 15 to 19 years old, with a mean age of 16. Among the 21 participants, 14 (67%) identified their race as African-American and 7 (33%) identified their ethnicity as Hispanic or Latina. Additionally, 15 (71%) of participants reported that they had been homeless in the last three months.

Types of Healthcare Providers Seen by Commercially Sexually Exploited Young Women in the Past Year (Figure 1)

Participants reported contact with multiple types of healthcare providers within the previous year, most commonly mental and reproductive health providers (Figure 1). Rates of utilization in the prior year were as follows: 81% had seen a mental health provider, 81% had seen a reproductive health provider, 76% had seen a pediatrician or general medical provider, 71% had seen an emergency room provider, and 62% had seen a substance use treatment provider.

Barriers and Facilitators to Healthcare

Participants identified key barriers and facilitators to accessing healthcare that were consistent across healthcare types. Tables 2 and 3 summarize the barriers and facilitators respectively; Figure 2 diagrams the interrelationship of these factors. We categorized barriers and facilitators as *internal* or *external*. Internal barriers and facilitators were specific to the participant (i.e., individual-level). External barriers and facilitators involved other individuals and environmental or systems-level factors. Barriers and facilitators reported by multiple young women are reported; themes are not mutually exclusive and, in many cases, overlap.

Barriers (Internal): Internal barriers to accessing care were: *being "on the run," fear of bad diagnosis, lack of health education, no identified need,* and *trauma triggers*. Participants

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commonly described *being "on the run"* (i.e., actively evading arrest by law enforcement) as a deterrent to utilizing formal healthcare. *Fear of bad diagnosis,* reported by most participants, described the fear of receiving a diagnosis perceived as life-threatening, such as HIV/AIDS, which caused an avoidance of seeking healthcare services. A few participants reported *lack of health education,* especially when care was indicated, as an additional barrier to care. Compounding this lack of awareness was the internal belief that seeking care was unnecessary, even if it was recommended or mandated by the court or group home; in our coding this is termed as *no identified need*. Multiple participants described self-reliance as a prominent factor for resolving health issues on their own and thus not viewing care as necessary. Finally, many young women reported *trauma triggers* in that several aspects of healthcare, especially pelvic exams and psychotherapy sessions, triggered past trauma related to their experiences of sexual exploitation and other prior abuse, which caused them to avoid care.

Barriers (External): We classified the external barriers to accessing healthcare as: *exploiter control, fear of mandated reporting, long clinic wait times,* and *negative provider experiences*. *Exploiter control* referred to traffickers inhibiting young women from seeking healthcare services. Some participants described feeling controlled by their trafficker, as traffickers often decided if and when they could access services. Many participants also expressed a *fear of mandated reporting*, causing them to feel reluctant to receive care and disclose their status as commercially sexually exploited. Often the fear of disclosure was driven by the CSE young women's fear of retribution by their trafficker (e.g. physical abuse or emotional threats of harm). Additionally, some were hesitant to report prior child abuse and unstable living situations for fear of disrupting their households or hurting their parents. Several expressed strong frustrations with *long clinic wait times*, stating that it symbolized a lack of respect for their time. *Negative provider experiences*, reported by nearly all participants, included negative provider interactions across several healthcare domains. Some described feeling disconnected from the provider, a fear of the provider sharing confidential information, feeling negatively judged by the provider, and discomfort from the presence of a male provider, especially for a pelvic exam.

Facilitators (Internal): Internal facilitators for accessing healthcare included *experiencing symptoms, a sense of emergency*, and *self-responsibility*. *Experiencing symptoms*, such as vaginal discharge or burning with urination, were common drivers for accessing health care as they contributed to a *sense of emergency*. Several participants feared having an STI. Some young women also described issues with mental health, such as excessive sadness or concern about untreated mental health symptomology, as a facilitator to seek mental healthcare. Participants frequently discussed a sense of *self-responsibility* (i.e., feeling pride in taking ownership of one's healthcare needs) as facilitating their access to care.

Facilitators (External): Participants all described external or environmental factors that influenced their access to and use of healthcare, including *accessibility of providers, cleanliness of clinic, confidential care, incentives, parental support, placement support,* and *positive provider experiences*. They conveyed an appreciation for free or low-cost care, as well as providers who delivered in-home care or services at readily accessible locations.

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Clinic environments that were clean and organized were highly valued; several participants reported a strong aversion to environments that seemed unclean. Participants voiced the importance of providers upholding confidentiality as a significant facilitator to care. They appreciated receiving snacks or home passes, which youth reported were sometimes offered by their providers as incentives for participating in care. Additionally, both group home staff and familial support strongly influenced utilization of services. Specifically, participants frequently related the importance of receiving information from group home staff and family members to assist with scheduling healthcare services, receiving transportation to healthcare services, and accompaniment to appointments. Finally, they articulated the impact of positive provider experiences or specific attributes that facilitated the utilization of services. Participants expressed motivation to access care from providers who encouraged autonomy, were flexible and patient, provided tailored education, and utilized humor.

Patterns of Healthcare Seeking Behaviors

Across healthcare needs, many participants used emergency rooms primarily for non-emergent conditions. When used for mental healthcare, they used emergency rooms for crisis-related care, such as concern for suicide or self-injurious behavior. Prior to commercial sexual exploitation, some participants described regular pediatric visits facilitated by caregivers. During and after exiting exploitation, however, they most often relied on care delivered by the child welfare or juvenile justice systems to receive routine care. This was especially true when they were residing in juvenile halls or group homes.

Reproductive Healthcare—Among non-crisis care needs, ambulatory reproductive healthcare was reported as participants' top healthcare priority. A frequent driver of accessing reproductive healthcare was suspicion of pregnancy or an STI following unprotected sex. Many young women described that access to reproductive healthcare was most often obtained via Planned Parenthood, stating that getting checked for STIs was part of what they perceived as routine care. Representative of this sentiment, one young woman stated, "If it has anything to do with the vagina, I always go to Planned Parenthood. It's really easy." In addition to Planned Parenthood, reproductive healthcare was also delivered via other community clinics accessed through group homes and when in detention at juvenile hall. Overall, the young women unanimously expressed feeling receptive to non-pregnancy related outpatient reproductive services such as STI testing and treatment, although preventive care was sought less often.

Some of the young women discussed positive and negative healthcare experiences during pregnancy. One participant described lacking stable placement or being "on the run" while pregnant. This inhibited her ability to receive continuous pre-natal care. Several young women also commented on unfavorable obstetric clinic conditions, especially long wait times to see providers once at appointments, or long wait times within the emergency room. One participant commented on inappropriate pre-natal care she had received while placed in a group home, where a medical provider offered to privately transport her and another young woman to a hotel room in order to deliver their babies. The young women who had experienced prior pregnancies described a lack of support from medical personnel and feeling judged by staff when seeking care, especially when seeking pre-natal care. The

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young women valued when they felt that their healthcare team saw their child as priority, appreciating that they were “tended to right away” during pre-natal visits. A few participants expressed appreciating receiving compassionate care during their pregnancies, which they described as smiles from staff, jokes, and friendly conversation.

Two young women discussed their experiences being pregnant while in juvenile hall. While they recognized and appreciated receiving the pre-natal care, they voiced disappointment about delayed care and a lack of compassion from staff. In an extreme example, one participant described experiencing pregnancy-related pain while in custody: “I was in so much pain and I was knocking the door and I remember the staff told me there are some other people that are sleeping here. And I was bleeding all over the place.” Although this was the only instance that untreated pregnancy-related pain was reported, both of the young women who discussed pre-natal care experiences while incarcerated expressed a desire to receive empathy from staff, a need they felt was most often unmet. For example, one participant stated that while detained and pregnant she felt “lonely” and “trapped,” while simultaneously recognizing “something important happening to my body.” Her statement typified the sentiment expressed by several participants who had been pregnant in detention that they felt both under-acknowledged in their pregnancy and insufficiently supported by juvenile hall staff.

Behavioral Healthcare—Participants frequently had histories of multiple systems involvement (e.g., juvenile justice, child welfare), resulting in prior experiences with several behavioral healthcare providers. As a result, mental health and substance use treatment was often fragmented as young women entered and exited multiple systems. Utilization of community behavioral health services was often sporadic. The young women often only accessed behavioral health therapy when detained or incarcerated in juvenile hall or when in a group home placement that directly facilitated access to behavioral healthcare. In rare instances, young women living on their own in the community who had developed a strong relationship with a provider continued to access care on their own, but this was the exception.

Some young women were motivated to seek mental healthcare; however, most had a strong distrust of mental health providers. This was largely related to feeling that providers did not care about them, therapeutic relationships were short-lived, providers did not have young women’s best interests at heart, and mandatory reporting requirements interfered with young women’s ability to disclose how they were really doing.

Fierce Autonomy: Conceptual Model of Commercially Sexually Exploited Young Women’s Engagement in Healthcare (Figure 3)

From these findings, the team developed the “Fierce Autonomy Conceptual Model for CSE Young Women’s Engagement in Healthcare” (Figure 3). Fierce autonomy is a self-determination model of resiliency, specific to commercial sexual exploitation, that illustrates our identified core components of CSE young women’s engagement in care. This conceptual model emerged organically from the interviews during our final phase of the qualitative analysis and is also framed by intersectional feminist theory. Intersectional feminist theory

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provided a lens through which to understand how these multiple-marginalized young women exhibited autonomy over their bodies and, in particular, their healthcare decision-making (Bettio, Della Giusta, & Di Tommaso, 2017; Sloan & Wahab, 2000).

In the Fierce Autonomy model, engagement in healthcare refers to when CSE young women exhibited "buy in" in their care. The model shows that predisposing factors, especially a history of family instability and child abuse or neglect, lead to commercial sexual exploitation. Commercial sexual exploitation then leads to high healthcare needs. However, a tension exists in the CSE young women's access to and engagement in care. CSE young women, who are often under control of their trafficker, often tend to develop a resolute attachment to preserving their decision-making capacity, or what we define as the concept of "fierce autonomy." While many vulnerable populations develop a sense of resiliency throughout their life trajectory, we identified that, within our sample, this will toward self-determination is amplified, resulting in a firm commitment to ownership over decision-making, particularly healthcare decision-making. The degree to which young women desire autonomy over their healthcare influences their level of engagement in care. The following statement reflects the depicted dynamic:

> "I learned while I was in there [group home], being in control even when I wasn't in control. I am very stubborn, but that's because I know what I want and I am not going to be deterred. I will have everybody that works with me try their best to work around what I need. I am not working around you guys, otherwise I might just be defiant and leave."

The "Fierce Autonomy" conceptual model illustrates a circular pattern that closely links commercial sexual exploitation and engagement in healthcare.

CSE Young Women's Recommendations

Participants had several recommendations to improve access to high-quality and trusted care, all of which indicate an overarching preference for autonomy. Table 4 summarizes the recommendations, including representative quotes; Figure 2 depicts recommendations pictorially alongside the factors they are intended to address. Overall, the CSE young women emphasized their need to have basic needs met, such as housing and feeling safe, and be self-directive in their care. Confidential care was an important element of feeling safe. Multiple participants specifically voiced appreciating mental health providers who were readily accessible (often via text messaging), flexible in meeting location (e.g. in the community or young women's home), and adaptable to the schedule and frequency of meeting preferred by the CSE young women.

DISCUSSION

CSE young women face significant health risks, and substantial internal and external barriers to accessing healthcare. Their healthcare needs, barriers to care, and utilization patterns directly relate to their experiences of commercial sexual exploitation. Understanding CSE young women's perspectives is critical to providing comprehensive care, and facilitating access and utilization. The demographic patterns observed among the CSE young women indicate a pattern of social marginalization. Young women in our sample were primarily

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African-American and Latina. Although prior larger studies have reported higher proportions of Caucasian youth (Curtis et al., 2008; Roe-Sepowitz, Brockie, Bracy, & Hogan, 2016), a consistent pattern is observed across sites of overrepresentation of racial and ethnic minority youth. Additionally, consistent with prior research, the majority of participants in our sample (71%) had been homeless or lived on the streets in the prior three months (Roe-Sepowitz et al., 2016). The qualitative findings highlight how these socially vulnerable young women interact with healthcare. The qualitative findings align with and further validate our prior CSE focus group study (Ijadi-Maghsoodi, Bath, Cook, Textor, & Barnert, 2017), provide additional insight into factors that influence access and utilization, and underscore the importance of cultivating CSE young women's sense of autonomy within the healthcare setting.

Engagement in Care

The extent to which the concept of engagement emerged from participants was striking. Findings suggest that histories of commercial sexual exploitation may create a strong desire for "fierce autonomy" that facilitates engagement in care for CSE young women, when the care is delivered on their terms. CSE young women's resilience has been shown to simultaneously create barriers to care and improve access, especially when they feel able to resolve health issues without assistance (Ijadi-Maghsoodi, Cook, Barnert, Gaboian, & Bath, 2016). Our study further exemplifies how CSE young women's resilience and desire for control over their healthcare experiences—and ultimately their bodies—influence their drive to seek care and their perceptions of that care. Many, but not all, CSE young women are often under the control of their trafficker, which can impede their ability to physically access care and limits the control they have over their own bodies. Given prior histories of abuse and lack of control over their own bodies, it is understandable that the CSE participants exhibited a "fierce autonomy" and highly valued control over their healthcare decisions. Provider attunement to the concept of "fierce autonomy" may help enhance provider compassion, empathy, and trauma-informed communication with CSE young women. Findings align with prior research supporting the important role of nurturing survivors' self-determination in their healing journey (Ladd & Weaver, 2018), which our data suggests as an important facet for increasing utilization and engagement of CSE young women in health services.

Related to the concept of "fierce autonomy," we found that participants had relatively high access to and utilization of healthcare, compared to the broader population of young women from racial or ethnic minorities. The high access and utilization were likely due to participant's involvement in the juvenile justice and child welfare systems. However, *utilization* did not necessarily equate with *engagement* in care. Many young women described being "checked out" or avoiding care, even when in juvenile hall with a therapist. For systems-involved youth, it is particularly crucial to differentiate utilization from engagement. Adolescent's engagement in healthcare is known to predict successful outcomes, and the converse likely holds—lack of engagement predicts worse outcomes (Hoagwood, 2005). This may be especially true for CSE young women as their recommendations highlighted the importance of autonomy in the young women's willingness to engage in care—or to actively disengage depending on how much choice they

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felt they had over the delivery of their care. Findings suggest the importance of cultivating active participation among CSE young women accessing healthcare, an emphasis that may be appropriate for all systems-involved youth in care settings.

Reproductive Health: Opportunities

Overall, CSE young women conveyed that reproductive healthcare was a high priority. Although participants reported relatively easy access to reproductive healthcare, they described a crisis-oriented pattern of utilization. Findings suggest that elements of reproductive healthcare, such as the pelvic exam and clinic setting, need to be perceived as less threatening to CSE young women for them to more regularly access preventive reproductive health services. Exploring ways to promote CSE young women's comfort in the clinical setting may increase utilization of services. Additionally, reproductive health education that emphasizes choice and agency is most likely to be effective for this population.

Behavioral Health: Opportunities

Participants conveyed high mental health and substance use treatment needs, yet their fragmented and often negative experiences with providers and healthcare systems created reluctance to access care—or when mandated—to engage in care. Several CSE young women residing in the community expressed difficulty accessing mental healthcare. Innovations such as co-location of mental health and reproductive health services may circumvent these challenges and provide more inroads to offer psychoeducation about mental health and substance use treatment. Preserving CSE young women's sense of agency over their behavioral healthcare is vital.

Implications for Healthcare Practice and Policy

When prompted, CSE young women clearly articulated means through which healthcare delivery could be improved, all of which centered on meeting basic necessities and promoting autonomy in healthcare decisions. Their recommendations aligned with the identified barriers and facilitators for care and are commensurate with their experiences of transience, danger, mistrust, and high health need among these young women. Notably, CSE young women desire access to basic necessities, safe clinic locations, and confidential settings where they can receive care without fear of legal retribution. Additionally, participants asserted that utilization of care could be improved with additional flexibility in meeting location, frequency, time, and mode of delivery (e.g. mobile application for therapy). Further exploration of these ideas, particularly identification of the relative importance of the barriers and facilitators, is warranted. Policies that focus on removing mutable barriers—in other words, those most opportune for change—should be explored. Policymakers, through direct partnership with survivors and service providers, can develop an agenda focused on bolstering the potent levers for improving access to care and removing more modifiable barriers, such as long clinic wait times. Incorporating survivors' voices can help ensure that survivors' immediate and long-term health needs are met, thereby allowing for the fullest possible recovery (Rajaram & Tidball, 2018).

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Limitations

The transferability and generalizability of these data are limited to the young women who consented to participate, all of whom were involved with our partner organizations and were female. Thus, the CSE young women who participated in the study were all connected to at least one system of care and may have had better access to services than CSE young women "on the run" or not involved in systems. The survey results are based on a relatively small sample for reporting of quantitative data (n=21). Additionally, young women who participated had to respond "yes" to the screening item asking if they had ever traded sex for something of value. Of note, 4 of the 25 young women who were invited for participation responded "No" to this question. The screening procedure may have selected for young women who felt more comfortable disclosing their commercial sexual exploitation, potentially biasing the sample towards young women at a later stage of their healing process. Our analyses of the interview transcripts with young women who responded "No" revealed similar findings, possibly because these young women were, at a minimum, at high risk of commercial sexual exploitation or potentially because of unmeasured factors. The wide age range of commercial sexual exploitation of youth can be challenging (Rothman et al., 2018) and the age range of our sample (15–19) did not allow us to examine differences between younger adolescents compared to transition-aged young women, especially those 18 and older who represent a legally distinct group and may thus differ in their access to services as well as types of services desired. Although our community partners serve adolescents as young as 13, given the age range of our sample, our results best speak to the experience of transition-age young women. At younger ages, young women may be more likely to access care through their pediatric provider, while young women at older ages are transitioning to adult health services and, when justice-involved, to the adult criminal justice system. At older ages, young women are also more likely to present with health needs more common to adults (e.g., high blood pressure), which may further impact health care utilization. Also, despite our team's attentiveness towards cultivating trust with the young women, the extent to which we were able to overcome trust barriers remains unclear. Finally, our interviews suggest that young women in different stages of commercial sexual exploitation may have different expectations and readiness for help from health professionals. As our sampling and data collection methods did not specifically ask about participants' level of engagement in exploitation at the time of the interview, this remains an underexplored dimension and a valuable opportunity for future research.

CONCLUSION

CSE young women were insightful about their healthcare needs and identified several distinct barriers to care. Participants indicated that care will be more effectively delivered when health professionals and health systems value CSE young women's "fierce autonomy" and facilitate them in meeting basic needs. Being attuned to the healthcare needs and preferences of CSE young women is critical for effective delivery of healthcare to this vulnerable population. Finally, learning how to increase CSE young women's engagement in healthcare may help develop best practices for how to effectively reach other marginalized and at-risk youth populations.

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Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Abbreviations:

CSEY	Commercially Sexually Exploited Youth
CSE	Commercially Sexually Exploited
CSEC	Commercially Sexually Exploited Children

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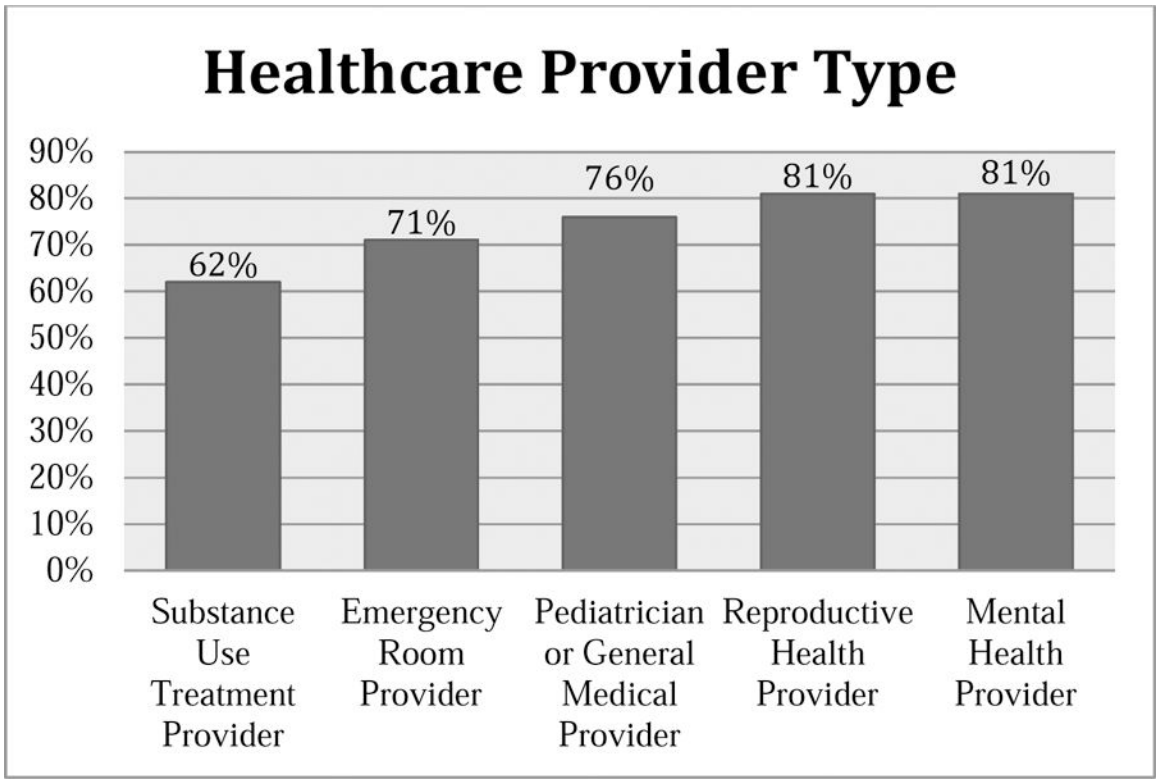

Figure 1.
Types of Healthcare Providers Seen by Commercially Sexually Exploited Young Women in the Past Year (n=21)

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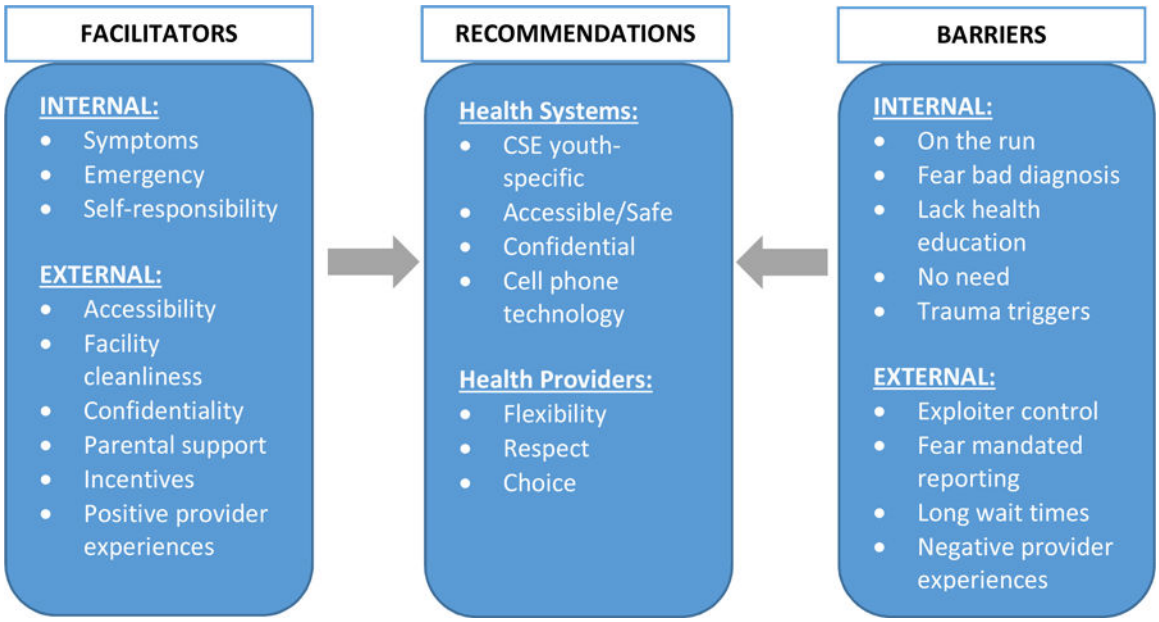

Figure 2.

Commercially Sexually Exploited Young Women's Identified Facilitators and Barriers to Healthcare, and Recommendations for Improving Access to and Engagement in Care

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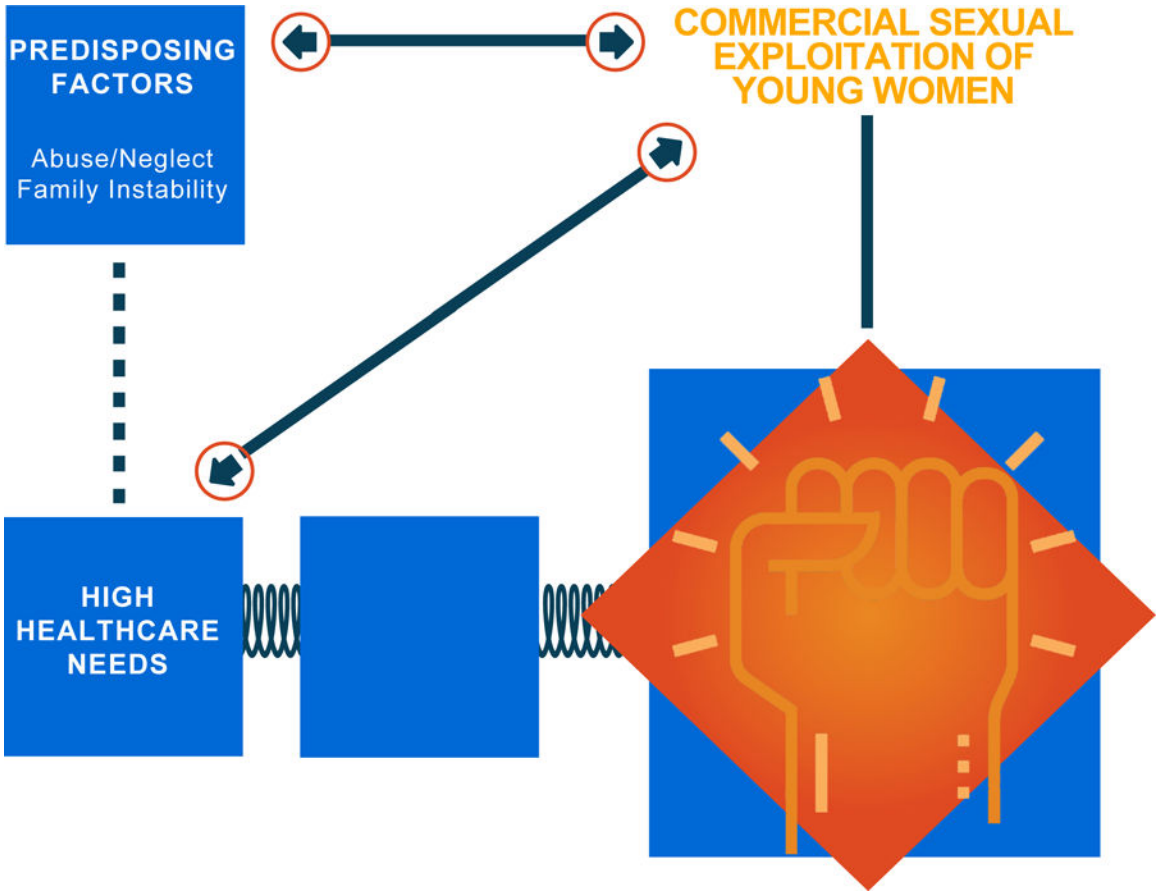

Figure 3.
Fierce Autonomy: Conceptual Model of Commercially Sexually Exploited Young Women's Engagement in Healthcare

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Table 1.

Participant Characteristics (n=21)

Characteristics	**N**	**%**
Age (years)		
15	3	14
16	5	24
17	7	33
18	4	19
19	1	5
Not reported	1	5
Hispanic or Latina		
Yes	7	33
No	14	67
Race		
American-Indian	2	10
Asian	1	5
African-American	14	67
White	4	19
Other	2	10
Unknown	3	14
Languages Spoken		
Only English	14	67
English Better than Spanish	3	14
Both English and Spanish Equally	4	19
Living in the Same Place in the Last 3 Months		
Yes	14	67
No	7	33
Place of Residence in the Last 3 Months		
Own House/Apartment	2	10
Parent(s) House/Apartment	9	43
Another Family Member(s) House/Apartment	1	5
House/Apartment of Friend, Boyfriend, or Non-Relative	3	14
Foster Home or Licensed Group Home	8	38
In a Rooming, Boarding, Halfway House, or Shelter/Welfare Hotel	1	5
Lived on the Streets or Homeless in the Last 3 Months		
Yes	15	71
No	6	29

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Table 2.

Commercially Sexually Exploited Young Women's Identified Barriers to Health Care and Representative Quotes

BARRIERS		
Internal		
Being on the run	"I was on the run. I was scared I was going to jail."	
Fear of bad diagnosis	"I'm afraid that one day I will have a fatal-ass disease."	
Lack of health education	"I had a urinary tract infection. I didn't know I had it though. So, I didn't go to the doctor."	
No identified need	"I didn't feel like I needed help. I just felt like, oh I could do it on my own."	
Trauma triggers	"I have previous experiences with being molested by men, so it's kind of uncomfortable to talk to a man...to expose those parts."	
External		
Exploiter control	"I try to rely on myself, but when I can't, I have to find a way to reach out to somebody. But even that's difficult because if the person that's trafficking you gets caught, you're going to be in deep shit. They're going to be after you."	
Fear of mandated reporting	"When you're being trafficked, you're doing it because you're either going to get hurt or killed if you say no. When you get hurt, help is not accessible because they're going to ask how it happened, and then they might report it."	
Long clinic wait times	"Well, the last time I went [to the clinic] I left because they took too long to see me."	
Negative provider experiences	**Disconnect**	"I don't want to talk to you cause you're nothing to me, you're just prescribing me my meds."
	Fear of shared information	"Maybe they get their funding through sharing our records."
	Judgment	"I don't really like the doctor here. She's weird. She's not a doctor to be comfortable with. She's judgmental."
	Male provider	"There have been a lot of clients here that have been raped and molested throughout their life. I don't think they should have to go to a male doctor if they feel uncomfortable."

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Table 3.

Commercially Sexually Exploited Young Women's Identified Facilitators to Health Care and Representative Quotes

FACILITATORS		
Internal		
Experiencing symptoms	"I felt something down there. So, I wanted to just make sure, and they examined me and, yeah, they found out like I had—yeah."	
Sense of emergency	"I'm like, 'It's kind of an emergency.' I was in Placement and that's when I saw the flyer for Planned Parenthood. I called them and I made my own appointment and stuff."	
Self-responsibility	"Maybe they [CSE youth] need therapists and all that help, because that's what I need. I know I need that. I'm going to get better really soon. They just got to come in."	
External		
Accessibility of providers	"We [my therapist and I] just meet. We just text and say wherever we want to meet at and we'll just talk for hours."	
Cleanliness of clinic	"I like when the clinic is organized, new walls and stuff like that so stuff doesn't look old – so people feel more comfortable."	
Confidential care	"Planned Parenthood is cool because other places ask for ID and stuff like that. You can't provide that if you're on the run, like if you're scared of the police and all that."	
Parental support	"My mom took me to the doctor because she scheduled it – that's her doctor too. So, they talk to set stuff up because they know each other."	
Placement support	"The camp program makes appointments for you and then they take you to get whatever medical attention you need."	
Incentives	"They would come and pick us up and take us to their office and they'd give us treats and stuff."	
Positive provider experiences	**Facilitated autonomy**	"Sometimes I get upset since I'm diagnosed with a lot of stuff. So, then she'd be like, 'What do you want to do?' and I'll be like, 'Let's just meditate' and then we just sit there."
	Patience	"Just give me my space. Give me my space and I will eventually open up to you. Know boundaries. Don't ask too many questions and I'll open up to you. You have to wait."
	Provides tailored education	"I like when the doctor tells you things, but in a polite way. Letting you know that this could happen if this happens. Just really explaining to you what's going on instead of shortening."
	Humor	"The counselor that I last had, she'd take me on walks and we'd talk about things. We'd joke around about things. She was just funny. She was able to make me laugh most of the time."

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Table 4.

Commercially Sexually Exploited Young Women's Recommendations for Improving Access to Healthcare and Representative Quotes

RECOMMENDATIONS	
Strategies for Health Systems	
Provide an accessible/ safe location for care	"I would make clinics that are accessible, where you feel safe, where you can stay for like a week or something. It will probably reduce the risk of catching something if you can just have a place to live. You know? Make it where it is accessible and it is anonymous and you know you are safe."
Text appointment reminders	"I wish they would set the appointments for me…just send you a message like, oh, you have an appointment today. That would be good because at the end of the day sometimes you just don't want to go to the doctor, but it could be useful to go to the doctor."
Increase confidentiality	"It'd be nice if there was a place or something where they're not there to rat you out or they're not there to take you in. You could just go in and talk to them. They can help you."
Develop CSE youth specific healthcare programming	"Having services that actually care about the girls would be the most helpful. Like, a CSEC [CSE youth] program where everybody comes together and talks about their problems and what they've been through."
Create a mobile application for therapy	"[We need] messages or someone available. Not something where they're going to go track you down and find you. Just someone you can talk to, you know?"
Strategies for Health Providers	
Increase flexibility in meeting frequency	"I think we need more accommodations between the counselor and the client itself. We should work around the client's schedule so that they receive the help that they need."
Treat youth with respect	"Don't force us into having a session with you…Casually talk to us like regular human beings."
Allow youth to choose healthcare provider	"I feel like you should be able to try different [therapists] and see which person you feel most comfortable with."