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Commercially sexually exploited youths' health care experiences, barriers, and recommendations: A qualitative analysis

Roya Ijadi-Maghsoodi[a,b,c,*], Eraka Bath[c], Mekeila Cook[d], Lauren Textor[e], Elizabeth Barnert[f]

[a] VA Health Service Research & Development (HSR&D) Center for the Study of Healthcare Innovation, Implementation & Policy (CSHIIP), VA Greater Los Angeles Healthcare System, 11301 Wilshire Boulevard, Bldg. 206, Los Angeles, CA, 90073, United States
[b] UCLA Nathanson Family Resilience Center, 760 Westwood Plaza, Rm A8-224, Los Angeles, CA, 90095, United States
[c] Department of Psychiatry and Biobehavioral Sciences, University of California, Los Angeles, 760 Westwood Plaza, Los Angeles, CA, 90095, United States
[d] Division of Public Health Practice, Meharry Medical College, 1005 Dr. D.B. Todd Blvd, Nashville, TN, 37208, United States
[e] Department of Anthropology, University of California, Los Angeles, 375 Portola Plaza, Los Angeles, CA, 90095, United States
[f] Department of Pediatrics, University of California, Los Angeles, 10833 Le Conte, MDCC 12-467, Los Angeles, CA, 90095, United States

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ABSTRACT

The current study sought to understand commercially sexually exploited (CSE) youths' health care experiences, barriers to care, and recommendations for improving health care services. We conducted focus groups (N = 5) with 18 CSE youth from February 2015 through May 2016 at two group homes serving CSE youth in Southern California. We performed thematic content analysis to identify emergent themes about CSE youths' perspectives on health care. Youth described facilitators to care, including availability of services such as screening for sexually transmitted infections, knowledge about sexual health, and a strong motivation to stay healthy. Barriers included feeling judged, concerns about confidentiality, fear, perceived low quality of services, and self-reliance. Overall, youth emphasized self-reliance and "street smarts" for survival and de-emphasized "victimhood," which shaped their interactions with health care, and recommended that health providers develop increased understanding of CSE youth. Our findings suggest that providers and community agencies can play an essential role in raising awareness of the needs of CSE youth and meet their health needs through creating a non-judgmental environment in health care settings that validates the experiences of these youth.

1. Introduction

The overlapping issues of *commercial sexual exploitation of children (CSEC)* and *child sex trafficking* are critical public health problems in the United States (U.S.). Roughly 4500 to 21,000 youth within the U.S. are commercially sexually exploited each year (Swaner, Labriola, Rempel, Walker, & Spadafore, 2016). The United Nations Palermo Protocol defines human trafficking as "the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation." The term exploitation includes both "prostitution of others or other forms of sexual exploitation." Further, under the Palermo protocol, a child

* Corresponding author at: 760 Westwood Plaza, Rm A8-224, Los Angeles, CA, 90095, United States.
E-mail address: RIjadiMaghsoodi@mednet.ucla.edu (R. Ijadi-Maghsoodi).

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(less than 18) meets the definition of being trafficked even without the use of the aforementioned means, including force, threat, abduction, deception, or the abuse of power (United Nations, 2000). In the U.S., the Institute of Medicine (IOM) defines CSEC as a range of acts where a minor is exploited for sexual purposes, this includes trafficking for sexual exploitation, exploiting through "prostitution," and involving in the exchange of sex acts for necessities, money, or something of value, among other crimes (Clayton, Krugman, & Simon, 2013). In 2013, the IOM highlighted significant deficits in knowledge among health professionals about commercially sexually exploited (CSE) youth and called for increased detection within the health community (Clayton et al., 2013).

CSE youth are at high risk for significant physical and mental health issues, including sexually transmitted infections (STIs), unwanted pregnancies, violence-related injuries, substance use disorders, depression, and post-traumatic stress disorder (PTSD) (Greenbaum, 2014; WestCoast Children's Clinic, 2012; Hossain, Zimmerman, Abas, Light, & Watts, 2010). Surveys conducted among trafficked youth and women receiving services in Europe found that 77% had probable PTSD and 55% had high level of depression symptoms (Hossain et al., 2010). One study found that 89% of female sex trafficking survivors experienced depression and 42% had attempted suicide while trafficked (Lederer & Wetzel, 2014). A study on CSE youth found that 70% reported substance use and 31% experienced sexual violence (Varma, Gillespie, McCracken, & Greenbaum, 2015). Many CSE youth have histories of prior adversities, including homelessness, victimization due to sexual orientation, and childhood abuse (Cochran, Stewart, Ginzler, & Cauce, 2002; Reid, Baglivio, Piquero, Greenwald, & Epps, 2017; Seng, 1989; Stoltz et al., 2007). A study of CSE youth in Burkina Faso found that 28% of the youth had suffered sexual abuse; 31% had an unwanted pregnancy; and 20% suffered various significant life events including the death of a parent, undergoing female circumcision, or community rejection (Hounmenou, 2016).

The health care system is a vital point of interaction with trafficked individuals (Baldwin, Eisenman, Sayles, Ryan, & Chuang, 2011). In Los Angeles, 50% of a sample of trafficked adult women saw a health provider while trafficked (Baldwin et al., 2011). Similarly to trafficked adults, CSE youth often present for health care; one multi-site study found that 64% had seen a physician within the past 3 months (Swaner et al., 2016). In New York City, CSE youth were most likely to present for care for a general check-up (42.6%), followed by STI testing (34.1%), and testing for HIV (20.9%) (Curtis, Terry, Dank, Dombrowski, & Khan, 2008).

Despite the extraordinarily high health needs among this population, best practices for health providers who serve CSE youth are underdeveloped. Surveys of physicians and medical students demonstrate that most providers lack training (Beck et al., 2015) and awareness of how to detect CSEC and, if encountered, how to respond (Titchen et al., 2015). Beyond the health care system, although CSE youth may interact with multiple systems of care, including law enforcement, child welfare, and other social service agencies, there is a lack of cohesion among service providers across disciplines on how to best care for CSE youth (Sapiro, Johnson, Postmus, & Simmel, 2016; Swaner et al., 2016). Furthermore, it is unclear what factors drive CSE youth to seek and engage in health services, the barriers to accessing care, or what type of services are most desired.

Qualitative research can illuminate experiences and voices of hard-to-reach populations and can potentially transform care (Israel, Eng, Schulz, Parker, 2005). Prior studies have interviewed stakeholders, health care professionals, and social service providers about CSE youth and their needs (Sapiro et al., 2016; Swaner et al., 2016). Qualitative studies among CSE youth have provided important perspectives on engagement with street outreach workers, and challenges faced by youth at risk for involvement in CSEC (Holger-Ambrose, Langmade, Edinburgh, & Saewyc, 2013; Kruger et al., 2013). The Office of Juvenile Justice and Delinquency Prevention sponsored a multi-site study of interviews with nearly 1000 sex trafficked youth, which provided a varied depiction of the lives of CSE youth throughout the U.S. and demonstrated high rates of health care and social services need (Swaner et al., 2016). Yet, there remains a dearth of studies focused on the barriers to health services and recommendations for improving care from CSE youths' perspectives, especially from youth residing in group homes.

Given the gap in the literature about how to best provide health services to CSE youth, we conducted focus groups with CSE youth in Southern California, including Los Angeles County, an FBI designated high-intensity area for CSEC. Our purpose was to explore CSE youths' perspectives on their health needs, experiences with physical and mental health care, and recommendations for improving health services, to best improve care for this important population.

2. Methods

2.1. Participants

Five focus groups were conducted with a total of 18 CSE youth residing in group homes, from February 2015 through May 2016, at two programs serving CSE youth located in a large metropolitan region in Southern California. All participants were female as the two programs served exclusively females. Youth were eligible for participation if they were: 1) between the ages of 12–19; and 2) if they identified as ever being sexually exploited for someone else's gain. Team members screened youth for meeting the eligibility criteria immediately prior to the focus group. Youth were asked to provide assent to participate in the study. Only one potentially eligible youth declined to participate. Participants received $20 in the form of cash or a gift card for participating.

2.2. Procedures

Focus groups ranged between 2 and 5 participants and lasted an average of 60 minutes. Four trained facilitators from the research team led the groups (RM, LT, MC, and EB). Prior to each focus group, participants completed a brief demographic survey. Race and ethnicity were assessed in order to provide demographic characteristics of the focus group participants. Racial categories were modeled after the U.S. Office of Management and Budget (OMB). The facilitators used a semi-structured focus group guide that explored: 1) participants' experiences with health care (including physical health, mental health, and substance use services); 2)