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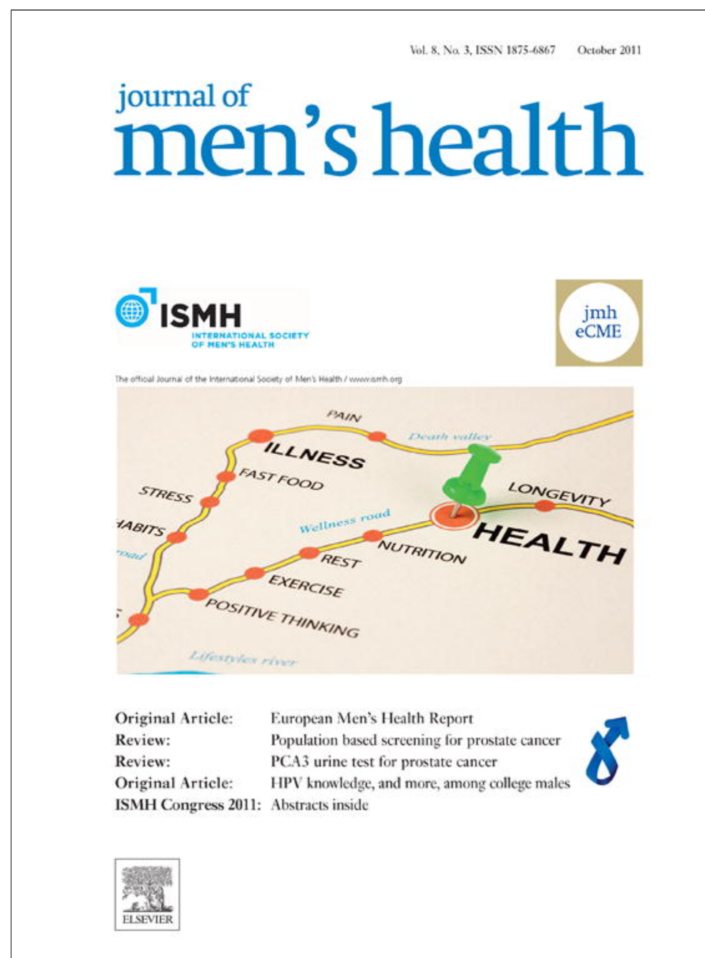

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The Invisible Men: finding and engaging with the male partners of street sex workers

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Keywords

Street sex worker
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Abstract

Men, in general, remain less likely than women to seek medical care, and are only half as likely as women to undertake preventive health visits and/or screening tests. There is a great need to increase men's health awareness and reduce this significant gender disparity. Furthermore, marginalised and socially excluded men rarely access health services, even though the reasons for their social exclusion, particularly drug and alcohol dependency, invariably mean that their need for health interventions is greater than in the normal population.
The Open Doors Sexual Health Service has been working with female street sex workers (SSWs) in the London Borough of Hackney since 2006, in order to help them address their physical, psychological and social needs. Open Doors is based in, and partly funded by, City and Hackney Primary Care Trust. As Open Doors' staff's relationships with the women grew and the team developed an understanding of the lives of the women and their networks, it became clear that their relationships with the men in their lives (historically characterised as ''pimps'') were more significant and enduring than had previously been assumed, and that working with couples had the potential to be of greater benefit than working with the women only.
In July 2008, a male worker joined the Open Doors team, in order to work exclusively with the male partners of women using the service, and to develop access to clinical and social services for this shadowy group. During the first 12 months, the male partners' coordinator (MPC) engaged with 23 men, each one of whom has needed intensive case management, as illustrated by a Case Study. The MPC's contract has been renewed for a further year, and the scope of the post widened to include other marginalised men, such as street drinkers, squatters and undocumented migrants, achieved by close collaboration with key services, especially the TB service, the Department of Sexual Health (DoSH) and the Specialist Addictions Unit (SAU) in Hackney's local hospital, the Homerton.
This paper will describe the work done by the MPC during the first 12 months of his tenure. © 2011 WPMH GmbH. Published by Elsevier Ireland Ltd.

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Introduction

Men, in general, remain less likely than women to seek medical care, and are only half as likely as women to undergo preventive health visits and/or screening tests. There is a great need to increase men's health awareness and reduce this significant gender disparity. Currently, there are no guidelines for medical practitioners to perform men's health maintenance and conduct preventive services for men in a gender-specific, racially and ethnically sensitive way. This is an area of highly unmet need and has a substantial public health impact [1]. Marginalised and socially excluded men rarely access health services, even though the reasons for their social exclusion, particularly drug and alcohol dependency, invariably mean that their need for health interventions is greater than in the normal population.

The London Borough of Hackney (LBH) is situated in London's East End. Historically it

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has been a first settling place for migrants over many centuries, as it lies near to the old port of London on the river Thames. Although the port of London has been re-sited a long way from the East End, the area still attracts large numbers of migrants from all over the world. Hackney is relatively small in area, compared to other London boroughs: there are 106 people per hectare, compared to the inner London average of 45, making it the third most densely populated borough in Britain. Furthermore, while the official estimate of Hackney's resident population is 209,700 people, local records place it 6% higher, at 223,171 people. The rate of homelessness is nearly twice the London average. Nationally, Hackney is the second most deprived borough in the country; 11% of the local population is unemployed, and 53% of children live in families on means-tested benefits. The prevalence of problem drug use (especially crack cocaine and opiates) in Hackney is high (32 users per 1,000 population) with only a minority (35%) in contact with treatment services. One consequence of this is the high rates of sexually transmitted diseases (STIs), blood borne viruses (BBVs), tuberculosis (TB), human immunodeficiency virus (HIV) and mental illness [2].

The LBH is home to many ''hard to reach'' populations, including the borough's street sex workers (SSWs). SSWs are typically nocturnal, with insecure or no housing, high levels of chronic drug and alcohol dependency and a range of other health and social issues, which make their lives both complex and chaotic. Since 2006, the Open Doors Sexual Health Service has been delivering health and other services to Hackney's SSW population. Between 2006–2008, Open Doors made contact with nearly 200 women per year. However, 2008/9 saw an increase of 35%, taking the number of women contacted to 260 in 2009. Open Doors' interventions range from distributing condoms, needle exchange and harm reduction advice during late night outreach sessions (11pm–3am, twice weekly). Women are also encouraged to attend the weekly daytime drop-in session, where more complex issues can be addressed. More than 95% of Hackney's SSWs are UK born, and most of them are local women, born and brought up in the borough. They are predominantly white British, or mixed race British. They range in age from teenagers to women in their late 40s [3].

Methods

Initially, all Open Doors staff were female, on the basis that the service was set up to address the needs of female SSWs. However, it became clear that many of the women had long-standing and complex relationships with men, who were not their ''pimps''. Often the relationship had endured over many years, and was based on drug co-dependency. Nearly all couples had had children removed, either at birth or shortly thereafter. The men were shadowy figures, often only glimpsed on late night outreach, or in the streets around the women-only drop-in setting. Conversations with the women suggested that these men were unknown to any health and social services, unless forced to engage through the criminal justice system.

Open Doors applied for funding for a male worker to take on the role of male partners co-ordinator (MPC), and he was appointed in July 2008 on a 12 month contract in the first instance. The post was specifically created to target this previously unrecognised community of men, and to try and support them in tandem with work already being done with the women. The core aims of the post were:

- to find and engage with male partners
- to facilitate their access into health and social services
- to create secure, fast track access into the relevant services
- to ensure that, as far as possible, couples were treated at the same time
- to create awareness within other services of the needs of this client group
- to offer joint case work and client support with other services
- to identify gaps in services, and work collaboratively to remove them

The man appointed to the MPC post already had an extensive knowledge of Hackney, as his previous post had involved assertive outreach with a local drug and alcohol team. He gained information about the women's male partners primarily through talking to the women, and asking if they would like their partners to have access to health and social services in the way that Open Doors had developed for them. He also went on late night outreach, in a Primary Care Trust car, with a female colleague, and

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gradually gained the trust of the women, and began to set up meetings with the men. These meetings would take place at a neutral venue, such as a coffee house or a park.

Case study

The case study described below demonstrates the kind of joint working that has been facilitated by the appointment of a MPC.

A (40) and B (39) have been married for 14 years. They have four children, all in the care of A's mother and extended family. As a result of chaotic class A drug use, A and B have spent the last 12 years living on the street, in squats, garages and crack houses. Their drug dependency is funded by B's sex work and A's petty, acquisitive crime. Neither is in receipt of benefits. They are both injecting drug users, HIV+ve and have hepatitis C. A also has TB.

B had been an Open Doors client for over 5 years and A was introduced to the MPC whilst on late night outreach. Over a period of 9 months, the MPC built a positive relationship with A, assessed his many needs and started joint work with the HIV, TB, BBV and SAU teams, as well as with housing. A was known to these services but engagement with them had never been consistent. The MPC was able to locate A and start encouraging him to access services. This was possible by meeting him at times and places appropriate to his lifestyle. The MPC also holds a small budget, which acts as a necessary engagement tool. This was used to help A with some basic needs such as food and clothes. A began to engage with the MPC on a regular basis.

Results and Discussion

The MPC post was based in the Open Doors office, and covered the same catchment area. His role quickly became well established amongst the female Open Doors' clients, who saw him on late night outreach and at the day time drop-in venue. It was imperative that he gained trust and credibility with the women, because it was only through them that he would be able to make initial contact with their male partners. It rapidly became apparent that the men's health and social problems were as complex as the women's, and that collaborative working with other agencies and organisations would be essential. During the course of the first 12 months, the MPC worked closely with the local HIV and TB teams, exploring ever more creative ways to access the male partners. Furthermore, the traditional "stone in the pond" approach to contact tracing often revealed a chain of connection to other marginalised men with similar histories of significant need and little or no history of engagement with services. Joint outreach has accessed men in some difficult places, including underground car parks, cemeteries, squats and crack houses. Part of the joint outreach with the TB case worker has included offering "on the spot" screening (taking sputum samples), while good links with the Hackney Crackdown Project, local police and the Hackney Estates Safety team mean that the outreach workers are given early information about transient groups, and emerging trends and "hotspots".

Sex and drugs

The MPC has negotiated for the male partners to be "bolted on" to already existing agreements between Open Doors and Homerton Hospital's Department of Sexual Health (DoSH). The male partners now have the same equally fast track access into this service as that of the female clients of Open Doors, and can choose to be seen either with their partner, or on their own. For men who find it difficult to attend appointments, the MPC is also able to offer "self testing kits", with results being given within 1 week. The MPC has also been able to expand existing agreements between Open Doors and local substance misuse services to include male partners. Previously, although some of the women were successfully engaged in treatment, positive gains were often short lived as their partner had not also been in treatment. Since the recruitment of the MPC, Open Doors staff have been able to engage both women and their partners in treatment simultaneously, increasing engagement, continuity, and retention successes. As fast track access into prescribing services is often the initial "hook" into other important services, the MPC has negotiated a weekly slot specifically for Open Doors clients to be assessed by the Specialist Addictions Unit

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(SAU) at Homerton hospital. All Open Doors clients are now offered low threshold prescribing on their first visit to the SAU.

Crime and stability

The MPC has negotiated access for the men to an existing agreement between Open Doors and the Hackney Homeless Persons Unit (HPU), which enables him to book his clients in for a temporary accommodation housing assessment within a very short space of time. With this stability of accommodation, clients are more readily able to engage with other health and social services. Many of the MPC's client group have spent much of their adult life involved in the criminal justice system. Some of the men are ''high profile'' offenders and the MPC is in a unique position to work with men who have previously made little or no progress in addressing their offending behaviour, often because criminal justice services have not recognised or been able to meet their complex needs. He is also able to engage with the men at times when they are not in an active cycle of crime, thus enabling them to explore new ways in which they can address their offending behaviour.

Data collected from 23 male clients was reviewed under two broad headings: health needs and social needs. The health domain was refined to reflect use of, or evidence of need to use, three specific services: the SAU, including the BBV nurse, the DoSH and the TB service (Table 1).

To summarise these findings within the public health context, most of the men had multiple health needs, but *all* were in the hard-to-reach, high-risk groups for transmission of, or infection with, HIV, TB, STIs and BBVs. Hackney has the highest prevalence of STIs in England, and these conditions all represent current, high level public health concerns, because of the ease of transmission into the wider public and the growing problem with drug resistance. For example, a recent World Health Organisation (WHO) report has indicated that strains of the *Neisseria gonorrhoea* bacteria are starting to become drug resistant and could soon become impervious to all current antibiotic treatment options [4]. In relation to sex workers and their partners, this population is characterised by a reservoir of infectious and communicable diseases which are transmitted to the wider population by the nature of their profession. There is an urgent need for an intervention that could block transmission and interrupt chains of contact between the reservoir and susceptible persons. The ''test and treat'' initiative might work well for this hyperendemic sub-group, and eventually interrupt the chain of transmission, as well as reduce incidence of HIV [5]. It is now accepted that individuals on treatment are 13-fold less infectious than untreated individuals. A recent analysis of an initiative that houses people with TB for the duration of their treatment has shown that interrupting the chain of transmission through ensuring treatment completion potentially prevented transmission of the disease to up to 100 other individuals. Other, asymptomatic conditions can also thrive within socially excluded groups. One in 12 Hackney residents under the age of 25 tested positive for *Chlamydia* in 2010 [6]. Known as ''the silent infection'' it is usually symptomless but can result in infertility if untreated. Until positive interventions in health promotion, education and disease prevention are implemented, hard to reach popu-

Table 1 Health and social care needs for male partners ($n = 23$) of SSWs in Hackney

Health needs:
73% ($n = 17$) were substance dependent
21% ($n = 5$) were HIV +ve
13% ($n = 3$) had tuberculosis (TB)
43% ($n = 10$) had blood borne viruses (BBVs)
Social needs:
This domain included 3 specific services: benefits, housing and legal aid.
A further agency, the criminal justice system (CJS), was considered separately.
56% ($n = 13$) qualified for one or more of the social services
60% ($n = 14$), were known to the CJS.

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lations represent continuing sources of potential disease outbreaks.

The most significant driver of the street sex work scene in Hackney is chronic addiction, usually to crack cocaine, heroin and alcohol, or any combination of these. Some women need to earn up to £300 per night, in order to support their habit. It is often assumed that street sex workers do not have steady partners. However, many of them do have male partners, and they carry out sex work in order to provide drugs for both themselves and their partners. Overall, the health of SSWs and their partners is poor. Most have had one or more STI, and there are high rates of HIV and TB. Other chronic problems include hepatitis B and C, cervical intraepithelial neoplasia (CIN), human papillomavirus (HPV) infections, abcesses from injecting drug use, cellulitis and other skin infections, severe and enduring mental health problems, and advanced dental decay. Furthermore, the women do not tend to seek treatment until their problems are at an advanced stage, while the men tend to avoid services all together.

Case resolution

A's health deteriorated, but he continued working with the MPC on an action plan agreed between the two of them. A began to recognise the importance of accessing health services and felt able to do this with support. Access was facilitated by the MPC and A was fast tracked through A+E and then admitted to Homerton Hospital.

During A's admission he was diagnosed with acute renal failure, and immediately began dialysis. However, he then made a decision to stop treatment and chose, instead, to go home to his mother where he was able to spend time with his family and his children, and where he was able to die with dignity. This important end-of-life choice was enabled by the joint work of all of the teams involved in his care. A month after his reconciliation with his family, he died peacefully at home. Sadly, B died a month later as a result of her chronic health conditions and lifestyle.

This case study demonstrates the considerable and complex needs of many of the MPC clients, and the importance of close, collaborative, inter-agency work. The health care teams involved in supporting this couple included TB, community HIV, DoSH, and the SAU, whilst social needs were represented by LBH Homeless Persons Unit, the benefits services and the temporary accommodation support team.

Conclusion

During his first 12 months in post, the MPC has challenged barriers and demonstrated the importance of partnership working as best practice in meeting the aims and objectives of the post. One of the biggest challenges when setting up a new assertive outreach service is in developing mechanisms to enable chaotic lives to be stabilised quickly enough for individuals to be successfully retained in services. Basing the MPC within City and Hackney PCT, as a part of the Open Doors team, means that it has been possible to agree fast track access into relevant acute health services at the Homerton hospital within a short period of time. These mechanisms are now well-established. The MPC then supports the work of these services with the male partners and has been able to identify further referral pathways if other services are required. The needs of this client group are complex, but locating the post within Open Doors and the local NHS, rather than within drug or probation services, meant that the response to the men's needs has evolved in a patient-led manner, rather than according to narrower, agency-specific criteria. The MPC has been able to provide a speedy and effective gateway into services, whilst at the same time demonstrating that services can, and should, establish innovative and client centred ways to identify, engage and retain hidden and marginalised groups and individuals.

The role of the MPC has the potential to become broader in scope to include working with men who are not necessarily the partners of sex workers, but who are revealed as inhabiting the concentric circles of contact around the client. These men are similarly socially disenfranchised, are characterised by the same complex health and social needs, and are also in need of multidisciplinary support and management. Broadening the remit of the MPC's job description, whilst building upon pre-existing collaborative work with the TB case worker and other outreach and liaison workers, would sharpen and extend the effectiveness of this post, and a new job description was drawn up to reflect this.

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