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Collaborating for consensus: Considerations for convening Coalition stakeholders to promote a gender-based approach to addressing the health needs of sex workers

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ABSTRACT

Women involved in sex work experience myriad challenges, such as poverty, illiteracy, low social status and gender inequity, as they struggle to access healthcare. These challenges place them at high risk for poor health outcomes. The purpose of this article is to describe the formation of a strong cross-system Coalition representing both the criminal justice and healthcare systems to address the health needs of sex workers in Delaware. The Delaware Coalition for Health and Justice implemented a Coalition-building strategy to design interventions and streamline systems to promote health and reduce criminal justice contact for sex workers. The sequential intercept model was utilized to organize Coalition membership and build consensus among varied stakeholders. The model assisted the Coalition in understanding differing primary objectives for key system programs, recognizing the limitations and barriers of each stakeholder group, sharing findings and discovering opportunities for partnership, and engaging stakeholders in designing and providing a comprehensive "systems" approach. This work suggests that aligning the criminal justice, healthcare, and community social services in a systemic process to build consensus can result in the implementation of effective systems change initiatives that address gender disparities and promote the health of justice-involved women.

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1. Introduction and background

Prostitution is recognized as a serious public health problem based on studies that have linked high-risk sexual behaviors and injection drug use to sexually transmitted infections, such as hepatitis A and C and HIV (Baseman, Ross, & Williams, 1999; Burnette, Lucas, Ilgen, Frayne, Mayo, & Weitlauff, 2008; Porter & Bonilla, 2000; Workowski & Berman, 2006). Studies of sex workers/prostitutes suggest that they are often challenged with complex and difficult-to-manage health risks such as drug abuse and addiction, mental illness, sexually transmitted infections (STIs) and untreated trauma (Abramovich, 2005; Farley & Barkan, 1998; Medrano, Hatch, Zule, & Desmond, 2003; Nuttbrock, Rosenblum, Magura, Villano, & Wallace, 2004; Roxburgh, Degenhardt, & Copel, 2006).

Nationally, 60% of incarcerated women have a history of drug dependence and/or co-occurring mental illness (Abram, Teplin, & McClelland, 2003; Mumola & Karberg, 2006; Sacks, 2004). This population of women involved in the criminal justice system has high rates of recidivism, and over 1 million women are either in jail or under community supervision (Greene, Pranis, & Frost, 2006; Maxwell & Maxwell, 2000). According to the United States Bureau of Justice Statistics, nearly three-quarters (73%) of women in state prisons in 2005 had a mental health problem compared with 55% of men in prisons (James & Glaze, 2006).

In studies of sex workers, 44% reported a known history of any STI, including genital herpes, gonorrhea, chlamydia, genital warts, syphilis and pelvic inflammatory disease (Cohan, Lutnick, Davidson, Cloniger, Herlyn, & Breyer, 2006; Kwiatkowski & Booth, 2000; Wojcicki & Malala, 2001). Women who have been incarcerated, including those incarcerated for sex work, typically have greater health needs and fewer resources than men who are incarcerated (Kramer & Comfort, 2011).

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The target population for our project was sex workers engaging in direct street prostitution. Street prostitution is characterized by solicitation in a public place such as a street or park. Clients are serviced in side streets, vehicles or short-stay establishments (Harcourt & Donovan, 2005). Delaware women, especially those in our target population of women involved in direct street prostitution, have disease rates for HIV infection, chlamydia, syphilis, gonorrhea and cervical cancer that are disproportionately high compared to national rates for women and rates for Delaware men (Leon & Ralston, 2010; Leon, Silverman, & Ralston, 2011). These high rates of diseases are in part a result of these women's inability to access and utilize healthcare because they often lack the support to initiate behaviors that would improve their health, especially in substance abuse treatment and safe sex practices (Leon & Ralston, 2010).

A review of the literature indicates that direct street sex workers such as those in Delaware experience gender-associated issues such as poverty, illiteracy, behavioral health disorders, societal pressures, norms and low social status that place these women at high risk for poor health outcomes (Bertakis, Azari, Helms, Callahan, & Robbins, 2000; Kurtz, Surratt, Kiley, & Inciardi, 2005; Newmann & Sallmann, 2004; Sallmann, 2010; Williamson & Folaron, 2003). National data are used to understand the problems inherent in prostitution because arrest rates specifically for prostitution are rarely representative of prostitution activity. Prostitution events that result in police interactions are often designated as disorderly conduct or loitering offenses. Estimates are that sex workers are officially arrested only once per 450 tricks (prostitution acts), with johns (customers) arrested even less frequently. Approximately 1 in 10 arrests of sex workers leads to a prison sentence, with a mean sentence duration of 1.2 years among that group (Edlund & Korn, 2002).

Breaking the cycle of recidivism among sex workers and addressing unmet health needs required the work of a strong cross-system Coalition representing professionals from both the criminal justice and healthcare service systems. Our challenge was to bring together two systems that rarely worked collaboratively. It became clear at the onset that Coalition building was essential to forge communication, eliminate barriers, and build "crosswalks" between the community systems that interacted with this population if we proposed to increase their access to much needed healthcare and behavioral health treatment (Butterfoss, Goodman, & Wandersman, 1996; Hays, Hays, DeVille, & Mulhall, 2000). Partnership-building activities culminated in the establishment of the Delaware Coalition for Health and Justice (Coalition) in 2010 to design interventions and to streamline public systems to promote the health of sex workers and reduce criminal justice contact for them. The Coalition was intended to provide a dynamic departure from the typical practice of revolving-door arrests of sex workers with few or no services for women and girls, which resulted in extremely high recidivism rates; 80% of arrested sex workers are repeat offenders. This population is vulnerable to continuing sexual exploitation, trauma and violence, which result in enormous costs to the criminal justice and public health systems (Kirshner, 2011).

We observed that judicial, probation and law enforcement officers were having repeated contact with an increasing number of the same individuals who had been arrested for prostitution and who were cycling through the misdemeanor courts, probation, and the prison system "under the radar" without receiving any type of clinical assessment or treatment services. These repeat offenders were predominantly women with charges linking them to prostitution and other related crimes such as loitering and drug possession in geographic areas known to be highly trafficked by sex workers and their customers (Leon & Ralston, 2010; Surratt, Inciardi, Kurtz, & Kiley, 2004; Williamson, Baker, Jenkins, & Cluse-Tolar, 2007). Criminal justice professionals seldom collaborate with behavioral healthcare providers to assist women seeking community-based health services (McCoy, Messiah, & Zhao, 2002; Zweig, Schlichter, & Burt, 2002). These systems have rarely worked together to address the unmet health needs of individuals with criminal involvement except in specialized court projects such as Drug Court (Koss, Bachar, Hopkins, & Carlson, 2004).

Based on a preliminary assessment, the Coalition focused on the expansion and enhancement of access to medical and behavioral health care and community support for criminal-justice-involved sex workers who were at high risk for HIV and other STIs. For the purposes of this paper, we selected the term "sex workers" to describe this population because we believe it is a less pejorative term than "prostitute," which connotes a tremendous amount of stigma and shame.

It is important to understand the context of health differences related to women to develop appropriate policies and programs (Nowatzki & Grant, 2011). Therefore, a gender responsive public health systems change initiative aimed at reducing recidivism and improving health and behavioral health outcomes was designed to address this statewide system need. By "gender responsive," we mean a response that places great emphasis on the unique needs of women, examining traditional procedures and practices, solutions, social norms, and potential for patriarchal bias that create sometimes insurmountable obstacles for women seeking health or criminal-justice-related change. The change initiative resulted in a restructuring of the links between the criminal justice system, the health/behavioral health care system and other community programs that serve women. We use the term "gender transformative" in this paper to underscore the increased value and intention we placed on ensuring that the modifications suggested and eventually adopted were truly transformational, eradicating patriarchal assumptions, introducing and then confirming the need for women-specific practices, policies, and procedures.

The system change required the initial Coalition founders to engage and retain all "change agents" or stakeholder groups involved with the target population. Based on studies suggesting that coalitions organized to affect practice have become increasingly popular in promoting health (Hatton, 2001; Kelly & St. Lawrence, 1990; Weissman, Melchior, Huba, Altice, Booth, & Cottler, et al., 1995; Zakocs & Edwards, 2006), the Coalition ensured that the membership reflected a broad range of stakeholders. The Coalition represents a public-private partnership of state agencies, service providers, researchers, consumers and advocates who are uniquely qualified to identify the effects of sex worker activity, develop community awareness and tailor intervention and prevention research to clarify precursors of sex work and best practices in health care and rehabilitation.

In late 2010, the Coalition received a *Coalition for a Healthier Community* (*CHC*) grant from the U.S. Department of Health and Human Services (DHHS) Office on Women's Health (OWH) to complete a comprehensive health needs assessment, gender-based analysis and strategic plan to address the unmet health needs of individuals engaged in sex work. Initial funding was used to conduct research and plan for a proposed set of interventions aimed at transforming the system.

The purpose of this paper is to describe the methods used to develop a social change Coalition and the results of this approach. An innovative methodology was employed using the sequential intercept model (SIM) as a tool for organizing the Coalition membership and planning activities (Munetz & Griffin, 2006). Barriers to implementation and lessons learned from the process are described. Our experience in developing consensus and balancing the varying and often conflicting interests of stakeholders resulted in valuable "lessons learned" that are important for other coalitions to consider when convening diverse stakeholder

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