International Journal of Gynecology and Obstetrics 128 (2015) 201–205

Contents lists available at ScienceDirect

International Journal of Gynecology and Obstetrics

journal homepage: www.elsevier.com/locate/ijgo

CLINICAL ARTICLE

Uptake of a women-only, sex-work-specific drop-in center and links with sexual and reproductive health care for sex workers

Soyoun Rachel Kim [a], Shira M. Goldenberg [b,c], Putu Duff [b], Paul Nguyen [b], Kate Gibson [d], Kate Shannon [b,c,*]

[a] Department of Obstetrics and Gynecology, Faculty of Medicine, University of British Columbia, Vancouver, BC, Canada
[b] Gender and Sexual Health Initiative, BC Centre for Excellence in HIV/AIDS, St. Paul's Hospital, Vancouver, BC, Canada
[c] Department of Medicine, University of British Columbia, St. Paul's Hospital, Vancouver, BC, Canada
[d] WISH Drop-In Centre Society, Vancouver, BC, Canada

ARTICLE INFO

Article history:
Received 10 June 2014
Received in revised form 22 September 2014
Accepted 17 November 2014

Keywords:
Health access
Health services
Outreach services
Peer-led
Reproductive health
Sex work
Sexual health
Support services

ABSTRACT

Objective: To longitudinally examine female sex workers' (FSWs') uptake of a women-only, sex-work-specific drop-in service and its impact on their access to sexual and reproductive health (SRH) services. *Methods:* For the present longitudinal analysis, data were drawn from the AESHA (An Evaluation of Sex Workers' Health Access) study, a community-based, open, prospective cohort of FSWs from Vancouver, BC, Canada. Data obtained between January 2010 and February 2013 were analyzed. Participants are followed up on a semi-annual basis. Multivariable logistic regression using generalized estimating equations was used to identify correlates of service uptake. *Results:* Of 547 FSWs included in the present analysis, 330 (60.3%) utilized the services during the 3-year study period. Service use was independently associated with age (adjusted odds ratio [AOR] 1.04; 95% confidence interval [CI] 1.03–1.06), Aboriginal ancestry (AOR 2.18; 95% CI 1.61–2.95), injection drug use (AOR 1.67; 95% CI 1.29–2.17), exchange of sex for drugs (AOR 1.40; 95%CI 1.15–1.71), and accessing SRH services (AOR 1.65; 95% CI 1.35–2.02). *Conclusion:* A sex-work-specific drop-in space for marginalized FSWs had high uptake. Women-centered and low-threshold drop-in services can effectively link marginalized women with SRH services.

1. Introduction

Sexual and reproductive health (SRH) services—including contraception, prenatal care, family planning, and abortion care—are a crucial component of women's reproductive rights [1]. In many international settings, female sex workers (FSWs) of reproductive age experience high reproductive and sexual health morbidity (e.g. unsafe abortions and genital tract infections) [2] and have suboptimal access to SRH services (e.g. contraception), largely because of social and structural barriers (e.g. stigma, criminalization, and restrictive funding policies) [3–5]. Most research and interventions with FSWs have focused on the prevention, treatment, and care of HIV and other sexually transmitted infections (STIs) [6]. Access and utilization of broader SRH services among FSWs—including positive sexual health resources, contraceptive access, family planning, and pregnancy and prenatal support—have been largely neglected.

Alongside a high burden of HIV and STIs among FSWs relative to the general population of women [2,4,6,7], studies show large SRH disparities, including poor access to pregnancy and parenting services, low rates of cervical cancer screening, a high burden of unwanted pregnancies, and low contraception use [5,8]. However, FSWs face increased risks for reproductive and sexual morbidity because they have multiple sexual partners and encounter gender and economic barriers to male condom use and contraceptive access and use [6,9].

FSWs face significant barriers to SRH access across low-, middle-, and high-income settings [6,8]. These barriers include the criminalization of sex work and HIV status non-disclosure, occupational stigma, discrimination by healthcare providers, limited knowledge of services available, reluctance to seek help from healthcare professionals because of mistrust, and social and health inequities (e.g. poverty, mental health issues, illicit drug use, and homelessness) [7–10]. In Vancouver, Canada, FSWs have also been found to face significant challenges while pregnant or caring for a child, including lack of financial support, fear of partner violence, avoidance of services as a result of fear of child apprehension, and stigma [11].

The substantial health disparities and barriers to care experienced by FSWs highlights the need for appropriate, nonjudgmental services and outreach programs, which can promote better SRH access. Most successful strategies to improve FSWs' access to HIV prevention and care have been based on community empowerment models, including health and support services led by FSWs and tailored to their needs [6,12,13]. For example, the IMPACT project in Mombasa, Kenya, included a peer-mediated intervention to prevent HIV and STIs, which increased

* Corresponding author at: St. Paul's Hospital, 608–1081 Burrard Street, Vancouver, BC V6Z 1Y6, Canada. Tel.: +1 604 804 9459; fax: +1 604 806 9044.
E-mail address: gshi@cfenet.ubc.ca (K. Shannon).

http://dx.doi.org/10.1016/j.ijgo.2014.09.026
0020-7292/

consistent condom use and access to SRH services [14]. Other effective strategies have been implemented in low- and middle-income countries (LMICs), such as India [15], Brazil [16], and Mozambique [17]. Although these programs have been shown to successfully link FSWs with health and support services [6], data from high-income settings such as Canada remain scarce.

In Vancouver, BC, Canada, the Women's Information Safe Haven Drop-In Centre Society (hereafter, WISH) is a service and support organization for street-involved women in sex work (i.e. those working primarily in outdoor/public spaces). In operation since 1987, WISH is the only late night drop-in space for FSWs that is open 7 nights a week (6:00 PM to 11:00 PM daily until 2013, when the hours were extended to 11:00 AM). It serves approximately 160–180 women per night and provides low-threshold services, such as hot meals, showers, hygiene items, clothing, harm reduction and safety supplies (e.g. bad date sheets, condoms), and referrals to social and health support services. In addition to these core services, WISH offers ongoing peer/FSW education and support programs, and clinics run by outreach nurses and nurse practitioners provide onsite basic primary care and referrals.

The aim of the present study was to longitudinally examine the uptake of WISH services over a 3-year observation period, and to longitudinally evaluate the relationship between WISH utilization and SRH service access for FSWs.

2. Materials and methods

For the present longitudinal analysis, data were drawn from an open prospective cohort, An Evaluation of Sex Workers' Health Access (AESHA), which initiated recruitment in January 2010. AESHA is a community-based study that was initiated in 2005 and has been developed and guided through longstanding collaborations with sex work, women's, and health services agencies and formative research [18]. The cohort includes female individuals (including transgender women) in Vancouver, BC, Canada, who are aged 14 years or older and have exchanged sex for money or resources within the last 30 days. All participants provide written informed consent. For the present study, data obtained between January 2010 and February 2013 were analyzed. The AESHA study holds ethical approval through Providence Health Care/University of British Columbia Research Ethics Board and is conducted according to the principles of the Declaration of Helsinki and Canadian Tri-Council Policy guidelines.

Because of the difficulties of recruiting stigmatized and isolated populations such as FSWs, as previously described [18], FSWs are recruited for the AESHA study using time-location sampling. A team of interviewers and outreach workers (including staff with sex work experience) conduct weekly daytime and late-night outreach visits to sex work "strolls" (public sex work locations [streets and alleys]), indoor sex work venues (hotels, massage parlors, micro-brothels), and other in-and-out call locations (e.g. private homes and bars) and online/self-advertising spaces across Metro Vancouver. A list of street and indoor sex work venues is identified through community mapping conducted with current/former FSWs [18] and regularly updated.

After enrollment, participants are followed up every 6 months. Follow-up visits take place at one of two study office locations, or at a safe and confidential location as identified by the participant. Participants receive CAN$40 at every semi-annual visit for their time, expertise, and travel.

At baseline and follow-up visits, a trained interviewer administers a main questionnaire to participants, which obtains information about individual characteristics, work environment, partner/dyad sexual risks, and protective factors (e.g. condom use and access to harm reduction). Additionally, a project nurse administers a counseling questionnaire before performing HIV/STI testing. The counseling questionnaire obtains information about physical, sexual, and mental health. Patterns of healthcare and social support use are also recorded. SRH services assessed include contraceptives, obstetric consultations, cervical smears, and HIV and STI testing, all of which can be accessed through community clinics, hospital, or outreach services.

Biolytical INSTI (Biolytical Laboratories Inc, Richmond, BC, Canada) rapid tests are used for HIV screening; reactive tests are confirmed by western blot at the British Columbia Centre for Disease Control (Vancouver, BC, Canada). Urine samples are tested for gonorrhea and chlamydia. Blood samples are tested for syphilis via rapid plasma reagin, and a *Treponema pallidum* hemagglutination assay is conducted for positive samples. All patients receive post-test counseling and treatment as needed, as well as referrals to services (e.g. drop-in services [including WISH] and harm reduction services).

The present analysis was restricted to FSWs who did not primarily work in more established venues (e.g. massage parlors), because WISH services are not tailored toward FSWs in more organized segments of the sex industry. The dependent variable for the study was a time-updated measure of use of WISH, based on a "yes" response at baseline and semi-annual follow-up visits to a serial measure of having accessed any services or resources at WISH in the previous 6 months.

Descriptive statistics (i.e. frequencies, proportions, medians, and interquartile ranges [IQRs]) for the baseline characteristics were calculated and stratified according to WISH use at baseline. Baseline characteristics were assessed using Pearson's χ^2 test for categorical variables and the Mann–Whitney test for continuous variables.

For longitudinal analyses, sociodemographic variables were considered as fixed variables. All other variables were time-varying, on the basis of repeated measures collected at semi-annual visits over the study period. Correlates of using WISH were examined using bivariable and multivariable generalized estimating equations (GEEs) with a logit link function for the dichotomous outcome. To adjust the standard error and account for correlations arising from repeated measurements on the same participant over time, an exchangeable correlation matrix was used. Variables chosen a priori and significant at $P < 0.05$ in bivariable analysis were considered for inclusion in the multivariable model. Backward model selection and quasi-likelihood under the independence model criterion value were used to build the final multivariable model, as has been done previously [18]. Two-sided P values, and unadjusted and adjusted odds ratios with 95% confidence intervals are reported. Statistical analyses were performed using SAS version 9.3 (SAS Institute, Cary, NC, USA).

3. Results

Of 547 FSWs included in the present analysis, 269 (49.2%) had used WISH in the 6 months before baseline interview. At baseline, FSWs who had accessed WISH services in the previous 6 months were older and more likely to be of Aboriginal ancestry than were those who had not used WISH ($P < 0.05$) (Table 1). Furthermore, participants who had recently used WISH were more likely to report using injection and non-injection drugs ($P \leq 0.001$) (Table 1). More than three-quarters of the participants had ever been pregnant (Table 1).

Of the 547 participants, 425 (77.7%) had returned for at least one follow-up visit, with medians of 3 visits (IQR 2–4) and 23.85 months (IQR 13.08–29.93) of follow-up. Additionally, 330 (60.3%) visited WISH at some point during the 3-year study period. The services most frequently accessed at WISH were food provision, make-up, clothing, and primary nursing care (Table 2).

In unadjusted GEE analysis, HIV seropositivity was significantly associated with visiting WISH in the 3-year study period (Table 3). Furthermore, FSWs who visited WISH were more likely to be of Aboriginal ancestry, have been born in Canada, be homeless, use injection and non-injection drugs, exchange sex for drugs, and work primarily in outdoor/public spaces (Table 3). They were also more likely to report physical/sexual violence by clients, accessing SRH services, and hospitalization for a health issue (Table 3). In the multivariable GEE model, variables that retained an independent correlation with accessing WISH were