PROCESS EVALUATION OF THE
STREET OUTREACH/NEEDLE
EXCHANGE PROJECT
OF SASKATOON DISTRICT HEALTH,
PUBLIC HEALTH SERVICES

A Thesis Submitted to the College of
Graduate Studies and Research
in Partial Fulfilment of the Requirements
for the Degree of Master of Science
in the Department of Community Health and Epidemiology

University of Saskatchewan
Saskatoon

By
Maureen L. Laurie

Spring 1999

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Head of the Department of Community Health and Epidemiology
University of Saskatchewan
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ABSTRACT

Public Health Services, Saskatoon District Health operates a street outreach project. Begun in 1990, the project goal is to address HIV risk reduction among street-oriented youth, sex trade workers, and injection drug users and their sexual partners. In 1993 a needle exchange service was added. Although evaluation was part of the original proposal for this service, it has never been completed. An evaluability assessment completed in 1995 determined that the needle exchange component was ready for a process evaluation.

This thesis reports the results of a process evaluation of the Street Outreach needle exchange service. A descriptive study design was used to determine who the service was reaching and how the service was delivered, particularly the services which are delivered from a mobile van. The objectives of the study were: i) to describe some aspects of service delivery, focusing on the service provided from the van; ii) to describe the Street Outreach needle exchange clients who are injection drug users (or have been within the last 6 months) and their risks for HIV, other blood-borne pathogens and sexually transmitted diseases; and, iii) to describe the clients’ perceptions of Street Outreach.

Three methods of data collection were utilized in this evaluation study: i) observation and discussion with staff about service delivery; ii) a user survey to gather information on demographics, sexual and injection characteristics of the clients, as well as clients’ perception of the services; and, iii) review of client statistical information, clinic statistical data, policy and procedures, inventory and management records. Program documents were reviewed and conversational interviews with selected key informants were conducted in order to describe the history of the Street Outreach program.

This process evaluation provided a clear description of the clients receiving the service, service delivery methods, and the clients’ satisfaction with the Street Outreach service. The findings indicated that Street Outreach needle exchange clients are at risk for acquiring HIV and other blood-borne pathogens because of their injection and sexual practices. Although knowledge of HIV transmission is high, clients do not always protect themselves and the findings suggest situations in which risky behaviours tend to occur. Most clients use the needle exchange service because they are assured of getting clean needles and as many as one third have used all the services provided by the mobile van. Satisfaction with Street Outreach service was high due to the staff and delivery of services from the mobile van.

The findings confirmed that the Street Outreach service is providing valuable services to a group at high risk for HIV and other blood-borne pathogens. The trusting relationship between the Street Outreach staff and the clients, in addition to the Street Outreach needle exchange service, is essential in addressing the health needs of injection drug users.
Outreach method of service delivery, provides a good opportunity to affect change within this hard-to-reach population. The program is reaching those it intended to reach when it was implemented. Suggestions for enhancing and improving the program are offered. An outcome evaluation to determine effectiveness would be beneficial to support continuation and funding of the Street Outreach needle exchange program.
ACKNOWLEDGEMENTS

My sincere appreciation is extended to those individuals who helped me in so many ways throughout my thesis. I would especially like to thank Kathryn Green, my thesis supervisor, for her time, understanding, and the expertise she so willingly shared during the course of this study. I would also like to thank Susan Wagner and Sandy Irvin, thesis committee members, for keeping me focussed and for their guidance and support.

My appreciation is extended to Saskatoon District Health, Public Health Services without whose support, this study would not have been possible. Helen Beaven, the resource librarian, was helpful in getting the articles I needed for background material. Dr. Clarence Clottey provided insight and expertise in the content area and was instrumental in providing the monetary incentives used for the client survey interviews. A special thank you to Suzanne Mahaffey who encouraged and supported the study from start to finish and who was always willing to help find solutions to the problems that arose during the course of the project.

I would particularly like to acknowledge the Street Outreach staff who worked with me during this study and to whom I attribute its success. If not for their willingness to share their thoughts about the program and clients, their help in recruitment and interviewing, and allowing me to ride with them to observe service delivery from the van, this study would not have been as complete. I am indebted to Jan Jonsson, Jacqui Barclay, and Cyndy Doxtator for all their help.
The contributions to the study by the Street Outreach clients who agreed to be interviewed and to share their stories with us are acknowledged with gratitude.

And last, but not least, I would like to thank my family for their ongoing support and encouragement. To my husband, Bob, not only for encouraging me as I went, but for sharing his wisdom in the area of applied research. To my children, Kolin and Mark, for understanding when I needed to focus on my work and could not share the computer. And, to my parents who have loved and encouraged me throughout my life—thanks to you all.
DEDICATION

This thesis is dedicated to my family in recognition of their ongoing love and support for all that I do. You have inspired me to be all that I can.

I would especially like to dedicate this thesis to my sister, Pat, who was diagnosed with lung cancer as I completed the final chapter. One of my challenges is over, while one of yours begins. With love and support, I know that you will meet the challenge before you.

_There is in the worst of fortune
The best chances for a happy change._

(Ancient Greek playwright)
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1. INTRODUCTION

1.1 Statement of the Problem

Injection drug use and human immunodeficiency virus (HIV) are escalating as major public health concerns. Despite recent advances in knowledge associated with HIV and acquired immunodeficiency syndrome (AIDS), HIV infection continues to increase at an alarming rate. In Canada, increasing numbers of women, young gay men, Aboriginal peoples and injection drug users are becoming infected with HIV.\(^{1,2}\)

The spread of HIV and other blood-borne pathogens (e.g., hepatitis B and C) has been facilitated by injection drug use. The principal factor associated with transmission of blood-borne pathogens among injection drug users is the practice of sharing needles and other injection equipment. Once an injection drug user becomes infected with HIV, several new infections can be spread, not only by sharing needles but by sexual and perinatal transmission.\(^3\)

Public health officials have implemented several approaches to address the intersecting issues of HIV, AIDS, and substance abuse within the injection drug population.\(^3\) Needle exchange programs have become the major component of HIV prevention strategies and work within the philosophy of harm reduction.\(^4\) They are intended to decrease HIV transmission associated with injection drug use by replacing used needles/syringes with sterile ones.\(^5\) In 1990, there were eight publicly funded...
needle exchange programs in Canada, and by 1996 there were hundreds.⁶

Like any health care service, it is important that needle exchange programs be evaluated appropriately. In order to maintain funding, needle exchange programs will need to be able to substantiate their effectiveness in preventing HIV infection. Proper evaluation can help to maximize the effectiveness of needle exchange programs.

In Saskatoon, Saskatchewan, Public Health Services (PHS) implemented a Street Outreach program in 1990 in order to prevent the spread of HIV and other sexually transmitted diseases. In 1993, a needle exchange component was added to the Street Outreach program. The program has been operating since that time and has never been evaluated.

1.2 Significance of the Study

Until recently, the incidence of HIV in Saskatchewan cities has been relatively low compared to other cities in Canada. A recent outbreak of HIV infection in Prince Albert has demonstrated that even smaller cities are not immune to the serious problems associated with injection drug use.⁷ The importance of this issue cannot be overlooked or neglected at a local level.

While it is impossible to know exactly how many HIV infections can be related to injection drug use, we do know that the numbers in the injection drug-using population are increasing. In Ontario, the number of new HIV infections due to injection drug use has doubled and in British Columbia, the numbers rose from 9 per cent prior to 1995 to 38 per cent in 1995.² Throughout Canada, this increasing trend is disproportionate
between men and women. For example, 6 per cent of AIDS cases in females before 1989 were attributable to injection drug use. From 1989 to 1996, the rate increased to 24 per cent. For men, during the same period, the figures rose from 1 per cent to 5 per cent.\textsuperscript{2,8}

It is unlikely that the HIV epidemic will explode within the general population to the same extent as it has among injection drug users.\textsuperscript{2} However, as it spreads through the general population, HIV and other blood-borne pathogens are facilitated by injection drug practices. In communities of injection drug users with high levels of risk behaviours (e.g., needle sharing and unprotected sexual intercourse), injection drug use can serve as a bridge linking two distinct populations, and can efficiently impact on the HIV rate in the other group. For example, young female injection drug users often pay for their drugs by working in the sex trade and as such, become the conduit between the injection drug and heterosexual communities. There are accumulating epidemiological data that indicate the HIV epidemic is being driven by infections within the injection drug-using population, their sexual partners and their offspring.\textsuperscript{2,9,10}

Direct medical costs of HIV infection are estimated at $100,000 per infection,\textsuperscript{2} while indirect economic costs based on loss of lifetime earnings could be as high as $800,000 per person.\textsuperscript{11} Lurie et al\textsuperscript{11} estimated that the median annual budget of needle exchange programs in the United States and Canada was $169,000. Given the escalating direct and indirect costs of HIV infection, if needle exchange programs are successful in reducing HIV and other blood-borne infections, reduction in health care costs would be substantial, not to mention the reduced suffering to those infected, their families and loved ones.
The first step in substantiating the effectiveness of needle exchange programs as a strategy for preventing and containing HIV infection is to make sure that the program is running the way it was intended. Unless a program has been implemented the right way, is reaching the right people, and is satisfying their needs, effectiveness is difficult to prove. It is also important that program delivery meets the standards of good practice. These are aspects that are generally covered in a process evaluation.

1.3 The Purpose of the Study

This thesis is a process evaluation of the Street Outreach needle exchange service provided by Saskatoon District Health, Public Health Services. According to Posavac and Carey, a process evaluation has three very important purposes. They state that these three purposes include, “documenting the extent to which implementation has taken place, the nature of the people being served, and the degree to which the program operates as expected”.

Patton concurs that process evaluation, by focussing on the internal dynamics and actual operations of a program, enables us to understand its strengths and weaknesses. Hawe, Degeling, and Hall add that process evaluations assess what the program participants think of the program.

Process evaluations provide valuable information about program operations and it is important that a process evaluation be carried out before an impact or outcome evaluation. Process data are necessary to monitor and defend prevention efforts. Without process data, impact and outcome data are difficult to interpret.
Process evaluations serve to:

i) identify and describe participants

ii) provide for quality assurance

iii) describe activities in the intervention and the extent of participant exposure

iv) elucidate the internal dynamics of program operations (e.g., what does the staff do?)

This evaluation was planned to provide PHS with a thorough description of the needle exchange component of the Street Outreach project by: i) describing aspects of service delivery, focusing on services provided in the mobile van; ii) describing who the program is reaching and the risks that predispose them to HIV, other blood borne pathogens and sexually transmitted diseases; and, iii) describing clients’ perceptions of the services being provided.

The primary source of data for this study was collected through a client survey in order to describe the Street Outreach needle exchange clients. The survey was done to supplement existing data collected on clients on a daily basis by the program staff, which is often inaccurate or incomplete. It provided valuable information on client demographics and lifestyle risks related to injection drug use, HIV and other sexually transmitted and blood-borne diseases.

The data gathered by observations of service delivery, along with client satisfaction measures obtained from the survey, allowed me to describe service activities and what the staff do to provide service.
The evaluation provides an historical overview of the Street Outreach project and its structure within the context of the Sexual Health program. The focus is on the needle exchange which is the largest service activity of Street Outreach. A thorough description of the Street Outreach needle exchange service is helpful in pointing out strengths and weaknesses of the program. The evaluation provides baseline data on the clients which will be helpful to PHS management in refining Street Outreach service activities so as to best address clients' risks and needs, and in making improvements to services being provided. Further, the evaluation gives clients the opportunity to provide PHS with feedback related to programming.

1.4 Research Objectives

There were three objectives and several sub-objectives of this evaluation study:

1. To describe aspects of Street Outreach service delivery, focussing on delivery from the van.
   
   1.1 To describe needle exchange.
   1.2 To describe condom distribution.
   1.3 To describe provision of health information.
   1.4 To describe client referrals.
   1.5 To describe testing and immunizing.
   1.6 To describe resources for service delivery.

2. To describe the Street Outreach clients who are injection drug users (or have been injection drug users within the past 6 months) and their risks for HIV, other blood-borne infections, and sexually transmitted diseases (STDs).
   
   2.1 To document the number of clients using needles.
2.2 To describe the sociodemographic characteristics of clients.
2.3 To describe clients' injection practices.
2.4 To describe clients' sexual practices.
2.5 To describe clients' knowledge of HIV, and hepatitis B and C, sexually transmitted diseases.

3. To describe clients’ perceptions of the Street Outreach services.

1.5 Conceptual Framework

Public Health Services is currently restructuring their organizational framework. As part of the restructuring process, seven program areas have been combined into four public health departments (Healthy Lifestyles, Healthy Growth and Development, Disease Control, Safe Communities) and one Central Administration and Technical Support department. Street Outreach is a project in the Sexual Health Program, which in turn is part of the Healthy Lifestyle Department.

Health professionals have become increasingly interested in using logic models to facilitate program evaluation. A program logic model has utility for program evaluation in public health at several different levels: organization, department, program, and special project. PHS has used a variation of the program logic model as the basis for their restructuring process at the departmental level.

A program logic model depicts the relationships between program objectives, activities, and indicators. The model contains outcome objectives which refer to program results or what the program hopes to accomplish. It also links process objectives, which specify what activities need to be done in order to meet the outcome objectives. As well, the model identifies process indicators which are the quantifiable measures or
countable indicators of service delivery activities. Logic models are useful in describing a program schematically in order to clarify program structure and how the objectives, activities, and indicators are linked.

Figure 1.1 depicts Dwyer's Program Logic model. Arrows indicate a sequential order. Outcomes are specified first and then the process or implementation objectives are specified. Process objectives (activities) are necessary to achieve the outcomes. Dwyer emphasizes the importance of developing activities to meet outcome objectives rather than developing outcome objectives to correspond with program activities. Dwyer assigns indicators for resources, but there is no corresponding process objective for resources.
Figure 1.1  Dwyer’s Logic Model

GOAL  

[Goals are statements written in broad terms, providing a general rationale for the program. They are directional, not quantifiable.]

↓

Target Group  

[Target group specifies or defines who receives the program.]

↓

Program Components  

[Program components are a group of program activities that appear to fit together conceptually (e.g., risk reduction, public education).]

↓

Outcome Objectives  

[Outcome objectives are statements indicating the desired end results of the program. They can be short-term and long-term and specify direction of the desired result.]

↓

Outcome Indicators  

[Outcome indicators are quantifiable measurements of the program’s performance.]

↓

Process Objectives  

[Process objectives specify the activities that need to be implemented to achieve the outcome objectives. They specify the characteristics of those actually receiving the program.]

↓

Process Indicators  

[Process indicators are the quantifiable measures of the process objectives. They are the indicators that program activities or services have been delivered.]

↓

Resources  

[Personnel and resources needed to implement the program.]
A process evaluation is concerned with how activities are implemented in order to achieve the outcome objectives. It uses specified process indicators to measure whether or not the activities or services have been delivered. Process evaluations usually determine who the program is reaching and their satisfaction with the service.

The following diagram depicts the conceptual framework for this evaluation adapted from Dwyer’s model. It shows Street Outreach in relation to PHS and depicts the program component (risk reduction) which is to be evaluated. The risk reduction component is the largest component and the area where program staff spend the majority of their time. Process objectives or program activities are shown for the risk reduction component. Needle exchange is the largest activity within that component and for the purpose of this evaluation will receive the most emphasis.

The goal and short-term objectives are those specified by PHS for the Healthy Lifestyles Department and Street Outreach, respectively. The long-term objective was written as it could be phrased in order to fit better with the Dwyer framework. Outcome indicators would need to be determined by PHS prior to an outcome evaluation. Client satisfaction has been included in this framework as a process indicator because some authors include client satisfaction measures in process evaluations (e.g., Hawe, Degeling, and Hall). This framework also includes the description of services as a single process indicator for simplification. For example, clients’ perception of services includes program utilization and access measures. It is necessary to have a thorough description of the service in order to understand how a service is delivered or how a program operates.

Resources needed for program delivery with respect to staff numbers are
discussed in section 3.2, Setting. Funding for Street Outreach is discussed in section 1.6.2, Current Services. Resources have been assigned an indicator, although there is no corresponding process objective.

Figure 1.2 Conceptual Framework for Street Outreach Evaluation

**Goal**
To optimize knowledge, attitudes, behaviours, and practices related to disease transmission for sexually transmitted diseases and HIV/AIDS

**Target Group(s)**
Street-oriented youth, sex trade workers, injection drug users

**Program Components**

- Risk Reduction
- Client advocacy/counselling
- Public Education

**Long-term Outcome Objectives**

- To have 100% of clients practicing safe injection and safer sex
- To ↓% clients who use injection drugs

**Long-term Outcome Indicators** (to be determined by PHS)

**Short-term Outcome Objectives**

To 1% clients who are knowledgeable about transmission and prevention of HIV, hepatitis B and C, STDs
To 1% clients’ self-care skills
Figure 1.2 Conceptual Framework for Street Outreach Evaluation continued

**Short-term Outcome Indicators** *(to be determined by PHS)*

---

**Process Objectives**

<table>
<thead>
<tr>
<th>To provide needle exchange</th>
<th>To provide condoms</th>
<th>To provide health information</th>
<th>To make client referrals</th>
<th>To provide testing, immunizing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Process Indicators**

<table>
<thead>
<tr>
<th># clients using needles</th>
<th># condoms distributed</th>
<th>-establish clients' knowledge of HIV, hepatitis B and C, STDs</th>
<th># clients referred</th>
<th>-identify where client referrals are being made</th>
<th>-# clients tested</th>
</tr>
</thead>
<tbody>
<tr>
<td># needles exchanged</td>
<td>-establish self-reported condom use</td>
<td>- identify types of health information given clients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-description of clients' sexual practices</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-description of clients' sociodemographic characteristics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-description of clients' injection practices</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

- description of aspects of service delivery
  - description of clients' perceptions of service

---

**Street Outreach Resources**

<table>
<thead>
<tr>
<th># staff, staff qualifications, resources, funding</th>
<th>(funding discussed in section 1.6.2)</th>
</tr>
</thead>
</table>

* arrows show linkages between specific components, process objectives and process indicators
The process indicators for the risk reduction component have been combined to make analysis easier. Table 1.1 lists the process indicators and their relationship with the research objectives for this study. Refer to the Methods chapter for details on the selection of indicators.

Table 1.1  Relationship between research objectives, sub-objectives and process indicators.

<table>
<thead>
<tr>
<th>Research Objectives</th>
<th>Process Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To describe aspects of service delivery</td>
<td>- description of aspects of service delivery&lt;br&gt;- # needles issued &amp; returned</td>
</tr>
<tr>
<td>1.1 To describe needle exchange</td>
<td></td>
</tr>
<tr>
<td>1.2 To describe condom distribution</td>
<td># condoms distributed&lt;br&gt;- # clients referred&lt;br&gt;- establish where clients are being referred</td>
</tr>
<tr>
<td>1.3 To describe health information given to clients</td>
<td></td>
</tr>
<tr>
<td>1.4 To describe client referrals</td>
<td></td>
</tr>
<tr>
<td>1.5 To describe testing, immunizing</td>
<td>- # clients tested&lt;br&gt;- # clients immunized&lt;br&gt;- # clients testing positive</td>
</tr>
<tr>
<td>1.6 To describe resources for service delivery</td>
<td>- # staff, staff qualifications, resources, funding</td>
</tr>
<tr>
<td>2. To describe the Street Outreach clients who are injection drug users &amp; their risks for HIV, other blood-borne infections &amp; sexually transmitted diseases.</td>
<td>- # clients using needles&lt;br&gt;- description of clients' sociodemographic characteristics (e.g., age, gender, education)&lt;br&gt;- description of clients' injection practices (e.g., frequency of injection, sharing behaviours, initiation into needle use)</td>
</tr>
<tr>
<td>2.1 To document # clients using needles</td>
<td></td>
</tr>
<tr>
<td>2.2 To describe client sociodemographics</td>
<td></td>
</tr>
<tr>
<td>2.3 To describe clients' injection practices</td>
<td>- description of clients' sexual practices (e.g., # sexual partners, self-reported condom use)</td>
</tr>
<tr>
<td>2.4 To describe clients' sexual practices</td>
<td></td>
</tr>
<tr>
<td>2.5 To describe clients' knowledge of HIV, hepatitis B&amp;C, and sexually transmitted diseases</td>
<td>- establish clients’ knowledge of HIV, hepatitis B&amp;C, STDs (e.g., how HIV is transmitted, knowledge of prevention strategies)</td>
</tr>
<tr>
<td>3. To describe clients’ perception of the Street Outreach service</td>
<td>- description of clients’ perception of service (e.g., utilization &amp; accessibility, satisfaction with services)</td>
</tr>
</tbody>
</table>
1.6 Historical Overview of Street Outreach and Needle Exchange in Saskatoon

1.6.1 Origin

In May 1990, the Saskatoon Community Health Unit (SCHU), now called Public Health Services, submitted a proposal for an AIDS/STD Educational Outreach Program to address the needs of a population at increased risk for acquiring HIV. The program proposal was based on the recognition that a prevention strategy against HIV, rather than an intervention strategy (e.g., clinical services), was needed. The proposal was to implement a three-year street outreach pilot program in Saskatoon to reduce the risk behaviours that facilitate the spread of HIV and STDs within a targeted group and their sexual partners. The target group was specified as street-oriented youth, sex trade workers, injection drug users and their sexual partners.

The proposed three-year pilot recognized the need to provide a mix of services through a cooperative effort of community services effectively serving the target group. The following services were suggested in the proposal:

1) Street Outreach (based in SCHU)
   - the provision of one-to-one counselling and education (sexually transmitted diseases, HIV), supporting safer sex and injection practices by material distribution (condoms, bleach kits)

2) Referral Network
   - making referrals to cooperating agencies in order to encourage the target group to access:
     - HIV antibody testing and counselling
     - treatment and rehabilitation
- health care
- other (food, shelter)

3) Needle Exchange

- provision of free sterile needles (syringes) to injection drug users

In June 1990, SCHU secured partial funding from the provincial government for the development of a ‘broad based’ street outreach program to prevent HIV/AIDS. Two outreach workers were hired in October of that year to distribute bleach kits and provide education and educational materials to street-oriented youth, sex trade workers and injection drug users. By 1991, the staff reported having made 89 contacts with injection drug users. Needle exchange was to be implemented at a later date.

In November, 1992 a proposal was submitted for the addition of a needle exchange to the Street Outreach program. By that time, epidemiological data suggested that the spread of HIV in the injection drug population was rapid and could rise very quickly.

Needle exchange began in March 1993. At that time, a mobile van was purchased in part with the help of a $10,000 donation from the Rotary Club. The purpose of the mobile van was to provide services that were city-wide rather than being limited to services provided from a fixed site. The SCHU management team suggested that the mobile van would allow the staff to meet the clients on ‘their turf,’ in addition to making the services more confidential in nature. New needles were to be distributed according to a one-to-one exchange; that is, for every new needle given out, a used one was to be returned. Initially, the program staff delivered new needles to clients’ homes if they were requested to do so. Requests to pick up containers of used needles were also responded
In October, 1993 anonymous HIV testing and screening for hepatitis B and immunization were added to the services being offered from the van, when the Street Outreach nurse was available to provide the service. The number of injection drug-using clients increased steadily throughout the 1993-1994 fiscal year. Over 150 drug users signed up for the program, with approximately 5,000 syringes being distributed on a monthly basis. The return rate for syringes was as high as 90% for some months.22

By March 31, 1995 over 250 injection drug users were signed up for needle exchange. According to the client statistical information there were as many as 6,500 syringes distributed per month by that time. The return rate was as high as 94% for some months. Hepatitis C screening was added to the testing services provided from the van by the nurse.23

1.6.2 Current Services

Street Outreach is a project in the Sexual Health program of the Healthy Lifestyles Department within Public Health. There are three staff who work in Street Outreach and provide services to a hard-to-reach population who would not otherwise access traditional health services. The staff provide needle exchange, other materials for risk reduction (e.g., bleach, condoms), referrals, counselling/support and health information to the Street Outreach clients, mostly from a mobile van. Testing for hepatitis B, C and HIV and immunizing against hepatitis B are provided by the nurse in the van or at the office, whichever the client prefers. Needles can also be exchanged at Hewgill’s pharmacy on 20th Street and the STD clinic. The STD clinic is operated by
PHS and is located at the main office on Idylwyld Drive North.

Section 3.2, Setting provides more detail on the Street Outreach program and the staff.

The Street Outreach staff made a total of 3,946 contacts in 1996 and 4,009 contacts in 1997. The staff spend the majority of their time doing needle exchange when they are working in the van. A total of approximately 200,000 needles were distributed last year. According to 1996 client statistics, 304 clients were registered with the program, 232 of which had accessed needles. While the number of clients accessing needles may appear to be lower than previously recorded, it is probably more accurate. In 1996, clients were issued new registration numbers to replace the old ones. Some clients were known to one staff member as one name and to another staff member as a different name. As a result, some clients were registered twice under two different numbers. The reassigning of numbers has helped to minimize this problem; however, problems still persist. For example, staff do not assign numbers in a consistent manner. One staff member may assign a number the first time a client accesses service, while another staff member may not. Clients are not always informed that they have a number and can use that number when accessing services at other sites. Client numbers are not always documented when needle exchange is done, especially at the STD clinic. For these reasons, it is difficult to assess which clients are active in the program.

There are no quotas (maximum number of needles given to any one client) on needles distributed. Clients are expected to return the same number of needles that they are given. However, this is difficult to track given the current method of documenting returns. The containers given to clients for needle returns are large so clients usually wait
until the containers are full before returning them. Clients request new needles in the meantime and are not denied needles because they did not return their used ones. Sometimes clients will tell the staff that someone else is returning their needles for them. When clients return needles, it is documented appropriately on the daily statistical form. Staff estimate the number of syringes returned by clients in each container and record the number on the statistical form. As a means of verification, the syringes have been counted at different times and the ‘eyeball’ method of counting has proven to be very close to the actual amount counted.

Funding for the Street Outreach programs in Saskatoon and Regina has been facilitated by grants from Saskatchewan Health. Currently, Saskatchewan Health provides $66,000 for needle exchange and street outreach in Saskatoon, of which $44,000 is specifically designated for needle exchange. The rest of the operating budget is provided by PHS.

Recent Controversy

A disturbing chain of events surrounding the provision of needles occurred in late August, 1998. A group of citizens belonging to a group calling themselves the Renewing Our Communities committee (ROC) organized to ‘clean up’ a Saskatoon neighborhood situated in the midst of an area associated with crime, prostitution and drugs. ROC wanted the vans operated by PHS and Egadz (a downtown youth centre) to stop providing health and counselling services to the sex trade workers in that area. They submitted a request to City Council to stop the vans from providing services on 21st Street. PHS halted van services for a week, fearing for the safety of the staff.

At the City Council meeting on September 8, concerned community
representatives and members of the ROC group spoke out against the services provided by PHS and Egadz. Proponents and supporters (individuals, agencies, staff) of both programs countered with compelling evidence substantiating the need for both services. Former ‘street people’ provided personal stories of how these programs were helpful in ‘getting them off the streets.’ The presentations to council were many, lengthy, and emotional. It was obvious from the presentations that many opponents were unfamiliar with the services being provided, particularly those provided by Street Outreach. PHS was accused of ‘aiding and abetting’ illegal activities by distributing needles and condoms. Council informed the group that they could not dictate where the PHS van travelled and referred the issue of prostitution and the problems associated with it to the city’s Safer City Committee.

A series of letters to the editor opposing the vans were published in the local paper, mostly from ROC members. The letters reiterated similar concerns, particularly about the provision of needles ‘aiding and abetting’ illegal activity. Others questioned the qualifications of the staff providing services. Since a series of letters supporting and clarifying the services was published, there have not been any letters printed in strong opposition.

In late September, Street Outreach staff and selected PHS management representatives, along with supportive community members conducted a door-to-door campaign in the Pleasant Hill area. The campaign was intended to inform the community about the services provided by PHS, to gauge the community’s reaction to the services, and to gain their support. Few residents objected to the services.
1.6.3 Summary

The Street Outreach program began in 1990 to provide outreach services to a hard-to-reach target group of street-oriented youth, sex trade workers, injection drug users, and their partners. The purpose of the program was to provide services (information, referrals) to a population at risk for acquiring HIV and sexually transmitted diseases. In 1993, the needle exchange component was added to provide sterile needles as an additional prevention strategy. Since that time, staff time spent on providing service around needle exchange has increased, although hours of operation have not. The majority of Street Outreach clients are injection drug users.

Since the origin of Street Outreach, a mobile van was added to improve service delivery by taking the service to the clients. The majority of contacts are made from the van. The STD clinic and a pharmacy on 20th Street are fixed sites where needle exchanges can be made during the hours they are open.
2. LITERATURE REVIEW

Prior to conducting this process evaluation, a literature review of needle exchange programs and evaluations of programs was undertaken. Data since 1989 were used to provide background information on needle exchange programs and their role in preventing HIV and other blood-borne pathogens. Databases searched include Medline, CINAHL, and the Internet. Canadian literature was emphasized. The resource librarian for PHS was instrumental in obtaining books and articles from other libraries in Canada (e.g., Addictions Research Foundation Library; British Columbia Centre for Excellence in HIV/AIDS; World Health Organization, Geneva) relating to injection drug use and HIV/AIDS.

Evaluations from needle exchange programs in Calgary, Toronto and Edmonton, as well as summarized evaluations from Montreal, Winnipeg, Vancouver, and University of California Report were reviewed. Personal communications with directors of needle exchange programs from Toronto, Winnipeg, Edmonton, Calgary, Vancouver and Regina were used to gather data on current program services.

Personal communications with researchers in the area of HIV/AIDS and substance abuse in addition to a police officer with the Saskatoon City Police's Integrated Drug Unit were used to further my understanding of the issues involved in working with the injection drug-using population.

In order to clearly describe the history of the program, I held conversational
interviews with select key informants and reviewed program documents (e.g., Street Outreach and Needle Exchange Proposals, SCHU Annual Reports).

2.1 Epidemiology of Injection Drug Use, HIV/AIDS

2.1.1 Injection Drug Use

The use of drugs, especially illicit drugs, is difficult to track in Canada. Although surveys provide the best source of information regarding drug use, they are limited. Information gathered on the quantity of the drug used, its purity, or dosage is difficult to collect. The measurements are not standardized and there are no comparable measurements of illicit drug use like there are for alcohol (e.g., a glass of wine or bottle of beer). There are wide variations with regard to dosage size and drug usage patterns.

Heavy drug users are hard to reach. Information on their patterns of drug usage and personal characteristics are hard to obtain using traditional research methods. Information may not be reliable or valid. Data are usually obtained from those who are already in the system, for example, needle exchange programs or treatment centres. According to 1991 figures, there were an estimated 100,000 injection drug users in Canada. A recent study estimated that there were 30,000 injection drug users in Ontario alone. In Saskatchewan, 12% of the 8,243 alcohol and drug centre clients in 1995/1996 reported injecting drugs at some time in their lives. The number of current injection drug users in treatment in Saskatchewan increased from 506 in 1991/1992 to 572 in 1995/1996. These numbers are likely underrepresented. According to the profile of injection drug users from the 1995/1996 data, there were greater increases in males and
non-Aboriginals, although Aboriginal clients made up 60% of the current injection drug users.28

Drug-related health problems range from blood-borne infections (HIV, hepatitis), endocarditis, and malaria to physical deterioration and death. Besides medical problems, illicit drug use is associated with multiple crimes, family disintegration, child neglect, economic ruin, and social dependency.11,29 Constable John Woodley with the drug enforcement unit in Saskatoon estimates that 90 per cent of the crime in Saskatoon is drug motivated.30

Economic costs of illicit drug use in Canada were recently estimated at $1.37 billion, with an estimated $823 million attributed to lost productivity related to illness and premature death.6 An estimated $400 million, annually, is for law enforcement 6 which represents four times more than the amount spent on health care and treatment for drug users.8

2.1.2 HIV/AIDS

HIV is a virus which has been isolated in different body fluids, but is most commonly transmitted between people through blood, semen31 and vaginal fluids. The spread of HIV is limited to sexual transmission, sharing contaminated injection drug paraphernalia, transmission from an infected mother to her child, transplantation of infected tissues or organs, and exposure to infected blood or blood products2,10,32

Sexual Transmission of HIV

Sexual transmission is the principal mode of HIV infection. Factors that tend to
facilitate transmission depend on the type and frequency of sexual intercourse and the prevalence of other risk factors, such as sexually transmitted diseases.

Women and heterosexual couples represent an increasing percentage of new HIV cases, many as a result of injection drug use\(^2\)\(^3\) or sexual contact with injection drug users. Women account for about 31% of the new HIV cases, most of whom have been infected through heterosexual intercourse.\(^9\) It is now estimated that one quarter of new HIV infections in women are due to injection drug use.\(^9\)

*Perinatal Transmission of HIV*

Perinatal transmission of HIV is low compared to other exposure categories, less than 1 percent of all AIDS cases reported in Canada.\(^3\)\(^3\) In perinatal transmission of HIV, the virus is transmitted from an infected mother to her offspring in utero, during childbirth or by breastfeeding. Most HIV infections in infants occur during the birthing process through contact with contaminated blood or secretions.

*Diagnosis and Treatment of HIV*

Diagnosis of HIV infection is made only by a serologic test. The test used currently is an antibody test. Initially, most people infected with HIV feel healthy and display no outward symptoms, although the virus begins to weaken the body’s immune system. HIV eventually damages the immune system so that it becomes incapable of fighting many pathogens, resulting in a wide range of problems usually occurring 10 to 15 years after infection and associated with lowered immunity, such as opportunistic infections or cancers.\(^3\)\(^1\) By this time, a clinical AIDS diagnosis is usually made.

Significant strides have been made in biomedical research involving HIV and
AIDS. Although a vaccine to prevent becoming infected with HIV could be years away,\(^3\) the advances in research have been encouraging. Combination drugs to treat AIDS patients have resulted in lowering the amount of virus in the blood. AIDS patients are living longer today than ever before.\(^{33,34}\) Unfortunately, there are still 3,000\(^2\) to 5,000 new HIV cases added to the numbers each year in Canada.\(^1\)

2.1.3 Injection Drug Use and HIV

To understand HIV in injection drug users requires an understanding of the converging issues of HIV, AIDS, and substance use.\(^2\) HIV in the injection drug use population is a public health concern in many countries, in many diverse cultures and political systems, and at all levels of economic development. Once introduced into the injection drug community, the spread of HIV is very rapid. This is largely due to sharing needles. Other reasons include ‘shooting galleries’ (places where drug users go to rent equipment, buy drugs and to inject), ‘dealer’s works’ (injection equipment provided by the person(s) selling the drugs), or ‘professional injectors’ (people who will inject others). All of these contribute to what has been called ‘efficient mixing’. (A glossary of terms is found in Appendix A). Viral transmission is facilitated by the large number of injectors who use the same needles and syringes, increasing the risk for blood-borne pathogens such as HIV or hepatitis B and C.\(^{35}\)

HIV infection has reached epidemic proportions in the injection drug-using community in Vancouver, B.C. There, an estimated 10,000 injection drug users live in a small geographic area, in the downtown eastside. The HIV infection rate in that
community is as high as 50 per cent and expected to reach as high as 80 per cent within the next two years. Currently in Vancouver, it is estimated that three people per day get infected with HIV. As a result, the provincial government committed $3,000,000 and Allan Rock, the federal health minister, pledged a further $1 million to combat the crisis. The money is meant to improve services by increasing needle exchange services and adding outreach workers and substance abuse workers.

Catherine Hankins speculates that the increasing number of HIV infection among injection drug users in Canada is due to changing drug patterns, centralized needle exchange programs and quotas on the maximum number of needles that can be exchanged daily, in addition to lack of access to appropriate treatment services.

Two types of behaviour are important when examining the problem of HIV among injection drug users: i) sharing contaminated injection equipment; and, ii) sexual behaviour.

2.1.3.1 Injection Behaviour

Injection drug users transmit HIV infection and other blood-borne pathogens, such as hepatitis B and C, to other users primarily through multi-person use of needles or injection equipment. Each time a needle is used it becomes contaminated with blood. If someone else uses the needle, the needle serves as a vector and, if the previous person was infected, infections can be transmitted.

Drugs Used for Injection Purposes: Changing Patterns

Heroin was once the drug of choice for injection drug users and it still remains
popular in some areas, as well as among some of the older injection drug users. However, cocaine is fast becoming the drug of choice for many injection drug users.\textsuperscript{6}

Cocaine has powerful mental and physical effects which build quickly and subside just as quickly. The high is usually sustained for a period of 20 to 45 minutes.

Certain drugs used by injection drug users are more popular in some cities than others, but usually belong to one of two categories: opiates, such as heroin or morphine; and stimulants, such as cocaine. Few drug users use one drug; most use several drugs or combinations of drugs,\textsuperscript{39,40} such as speedballs (a combination of heroin and cocaine). In Saskatoon and Edmonton, many injection drug users inject ritalin and in other places, ritalin is used in combination with talwin (a narcotic)\textsuperscript{6} and referred to “T and Rs”.

Social Environments, Social Networks and Injection Drug Use

Initiation of drug use occurs for a variety of reasons: curiosity, desire to join in, family environment (e.g., separation, communication problems), and peer influence—particularly in adolescent drug users. Novice injection drug users usually do not own their own equipment and require help injecting for the first time.\textsuperscript{10}

Injection drug users can inject alone, but most often they do so in groups comprised of their friends or relatives. In larger cities, ‘shooting galleries’ (communal injection sites) are common. Large groups of people go to the galleries, located in apartments or abandoned buildings, where they can rent or buy injecting equipment. Although little is known about the dynamics of groups in relation to injection drug use, group injecting is enhanced by pragmatic issues such as the pooling of limited resources (money, drugs, injection equipment) and in some cases, as a means of protection against
violence or the law. Some groups are stable and do not appear to take risks (e.g., do not share needles or injection equipment), while others are less strict and exhibit more risk-taking behaviours (e.g., re-using needles and equipment used by others).

Several environmental factors influence unsafe injection practices in injection drug users. These factors include difficulty in planning ahead, the desire to shoot up immediately, the belief that HIV is a fragile virus which dies quickly (and is therefore not easily transmitted), and not being careful when under the influence of drugs. The provision of large centrally located or centralized needle exchange sites may have provided injection drug users with new social networks by attracting them out of their own neighborhoods, bringing them together with other users. As a result, new injecting networks may have been created, increasing the 'efficient mixing' for transmission of the virus.

Needle Sharing

Needle sharing, or multi-person use of needles or other drug injection equipment (the 'works'), is the principal means of transmitting HIV and other blood-borne infections within the injection drug user community. Needle sharing can be of two types: direct or indirect. Direct sharing refers to re-using a needle that has been used by someone else. Indirect sharing refers to re-using injection equipment or paraphernalia such as cotton, filters, or rinse water used by someone else.

Studies have identified many factors associated with needle sharing. These factors include: age (younger injection drug users), lack of access to clean needles, unemployment, history of incarceration, lower levels of education, heavy drug use, type
of drugs used, number of drugs used, attending shooting galleries, peer influence, attitudes toward sharing, economic motivation, frequency of injections, homelessness, fatalistic attitudes, and psychiatric problems. Some studies have identified gender as a factor in needle sharing.\textsuperscript{44,46,54} In these studies, women shared more than men, but tended to do so with their male sexual partners. Most males in these studies did not have partners who injected drugs, and tended to share with friends.

VanCalo\textsuperscript{41} identified two contexts for needle sharing: i) sharing motivated by craving, or confusion due to the cumulative effect of the drugs and possibly alcohol; and, ii) voluntary or planned risk-taking done within the context of a trusting relationship. Bardsley\textsuperscript{55} provides yet another context for needle-sharing which he describes as a social-ritual context. Guydish, Golden and Hembry\textsuperscript{56} concur that nearly all injection drug users report having shared at some point and that needle sharing is often part of an initiation process. New injection users typically use 10 to 20 needles before getting their own equipment. Needle sharing forges a social bonding during initiation into injection drug use.\textsuperscript{40} As such, this entry into injection drug-use culture is a socialization process in which habits, rituals, expectations, and the means of survival are learned and shared within a group.\textsuperscript{56}

2.1.3.2 Sexual Behaviour

Sex and drug use appear to be inextricably linked and in some contexts, impossible to separate. The linkages among injection drug users, heterosexual and perinatal transmission of HIV infections are often facilitated by drug use or misuse.\textsuperscript{57}
Once HIV enters a drug-using sub-culture, heterosexual transmission among injection drug users and from them to non-injecting drug users can result. Women are particularly vulnerable to heterosexual transmission of HIV because male injectors frequently have non-injecting female partners. As HIV becomes established, the male may be infected through sharing needles and pass it on to his female partner through sex. If the woman becomes pregnant, she can transmit the virus to her offspring.57

A further risk to the heterosexual community results when sex is traded for drugs or money. For some female injection drug users, sex provides the principal means for obtaining drugs. Reports indicate that as many as 25 per cent of female injection drug users engage in prostitution.3 Prostitutes are at risk for HIV through both sexual and drug use behaviours.10

2.1.4 Summary

The major proportion of new HIV infections in the United States and Canada results from the spread among injection drug users, their sexual partners and offspring.3,10 The principal means of HIV (and other blood-borne) infections among the injection drug population occurs through sharing contaminated needles. Sharing needles and injection equipment are wrapped up in social networks and social environments. As such, these factors can effect and confine the extent to which individuals engage in risk reduction. Drugs and the changing patterns of drug use have been major factors in facilitating the spread of HIV and other blood-borne pathogens in the injection drug-use communities. Heterosexual transmission of HIV is increasing and this, in part, is related to
injection drug users. Sex and drug use are often bound together and almost impossible to separate. The injection drug user can facilitate HIV transmission by acting as the bridge between both groups. This frequently occurs when sex is traded for drugs or money.

While provision of sterile needles has merit as a strategy to reduce the risk of HIV in a high-risk population, it does not appear to be enough. Needle exchange must be part of a comprehensive approach.

2.2 Needle Exchange Programs

2.2.1 History

A needle exchange program has been defined as, "a facility where drug injectors can obtain sterile needles and syringes and return used injection equipment." Needle exchange programs have emerged around the world in an attempt to contain HIV and other blood-borne pathogens. They have become the major component of most HIV prevention programs for injection drug users. The goal of most needle exchange programs is to reduce transmission of blood-borne pathogens, particularly HIV, by providing sterile needles and education about safer injection practices through accessible services based on harm reduction strategies. Almost all prevention programs focus on sexual behaviour and injection drug use.

The first needle exchange program was developed in Amsterdam in 1984 to prevent the spread of hepatitis B when an inner-city pharmacy planned to discontinue selling syringes to injection drug users. The program, called 'Junkiebond' was started by injection drug use interest groups comprised of policymakers, drug service
agencies and users themselves.\textsuperscript{61}

The catalyst for needle exchange programs in Canada resulted from epidemiological data on increasing HIV infections in various geographic locations across Canada. For example, in B.C. between July 1987 and October 1988, the percentage of AIDS cases in heterosexual couples almost doubled, increasing from 1.6 per cent to 3 per cent during that period. Along with the mounting evidence of substantial increase in the prevalence of HIV in Montreal during the latter part of the 1980’s, the federal government responded by offering cost-shared funding for a period of two years or less to start comprehensive programs that included education, counselling, and risk reduction strategies with optional needle exchange services in order to prevent HIV.\textsuperscript{6,11,60} Quebec, Ontario, B.C., Alberta, and Manitoba accepted the funding and needle exchange pilot programs emerged.\textsuperscript{6,60,63}

Although aspects of these programs varied, most operated within a multi-faceted, multi-agency approach to drug use as was required by the funding conditions. Needle exchange in conjunction with other services to provide education, counselling, support for behaviour change (including provision of condoms and bleach), and linkages to other health and social services, such as addiction treatment services\textsuperscript{6} were instrumental in making needle exchange programs more acceptable in Canada.\textsuperscript{11} By 1990, several needle exchange programs were established across Canada and by 1996, there were hundreds of programs with mobile vans, fixed sites, and/or street outreach.\textsuperscript{6}

Opponents to needle exchange programs voiced concern over issues of increase in illicit drug use and a decline in the number of drug users accessing treatment services.\textsuperscript{24}
Concerns about the possible increase in the number of new injectors were also mentioned. Proponents suggest that none of these concerns have been warranted. Findings consistently show clients have reduced the risks, but have not eliminated them entirely.\textsuperscript{11,39,51}

Needle exchange programs in Canada are funded primarily in two ways: i) government funding that began as a cost-sharing federal initiative, gradually replaced by provincial funding; and ii) through community-based organizations.

\subsection{2.2.2 Types of Programs}

Needle exchange programs were developed as a part of a comprehensive strategy to prevent HIV. No needle exchange program has ever been intended to operate as a single intervention.\textsuperscript{59} Most needle exchange programs provide sterile needles/syringes along with bleach and alcohol swabs, in addition to the necessary supplies for safe injection practices such as safety containers and health information and condoms.\textsuperscript{3,64,65} Most have a knowledge-means approach to prevention; that is, a specific target group is given education about the epidemiology of HIV which includes information on transmission, in addition to the means to effect change.\textsuperscript{59}

Other comprehensive services to prevent HIV (and other blood-borne pathogens) include hepatitis B immunization, screening and testing, support to make behaviour changes, advocacy, needle disposal education and follow-up services.\textsuperscript{66} Some programs provide shampoo, tampons, flu immunizations, vitamins, and cold preparations, in addition to basic survival needs such as blankets.\textsuperscript{67} Referrals to appropriate drug
treatment centres and social services have been a large part of the comprehensive approach to needle exchange programs, which explains the face-to-face approach to service delivery in most programs.\textsuperscript{62}

Most of the needle exchange programs in Canada offer needle exchange services from both fixed and mobile sites. \textit{DEYAS} in Vancouver has a fixed site, open between 8:30 a.m. and 8:00 p.m. and three different van schedules providing around-the-clock service. Since the current HIV infection crisis in Vancouver, additional funding has been designated to extend outreach services.\textsuperscript{68}

\subsection{2.2.3 Staffing}

Lurie and Chen\textsuperscript{69} report wide variations in needle exchange program staff, related to available resources. Needle exchange programs usually desire staff diverse in terms of gender, sexual orientation, and ethnic backgrounds. Staff comprised of health care workers (nurses), other professionals (social workers) and peers (injection drug users) provide services. In Vancouver, most of the staff are former ‘street’ people and former injection drug users. That program initially began with nurses working from a van, but the nursing component of the program was dropped in 1993. In September 1997, a health van with nursing staff was added to \textit{DEYAS} to provide nursing services to their high-risk injection drug-using population.\textsuperscript{68}

According to the literature, staff qualities deemed necessary when working in needle exchange programs are non-judgmental attitudes and ‘street smarts,’ in addition to a nursing background in order to provide more flexibility in services. Pivotal to success
is the need for clients to develop trust in the program staff\textsuperscript{56} and for the service to be 'user-friendly.'\textsuperscript{59}

2.2.4 Policies

Policies are rules governing needle exchanges. Policies vary as much as the types of needle exchange programs. Most programs have a one-to-one exchange; that is, clients are given starter needles and after that, they are expected to exchange one dirty needle for one sterile needle.\textsuperscript{3}

Quotas are the maximum number of needles that can be given out per client in a day. Programs initiated quotas most often in response to limited resources and supplies\textsuperscript{3} and for political expediency.\textsuperscript{6} For some programs, quotas allow staff to monitor the health of their clients more closely.\textsuperscript{68} In Vancouver at \textit{DEYAS}, clients are allowed a maximum number of 50 syringes per visit per day. In Winnipeg at \textit{Street Connections}, clients are allowed up to 500 syringes per person per day. Some programs (e.g., \textit{CACTUS} in Montreal) have since abandoned their quotas, believing that it no longer makes sense to restrict access to sterile needles given what we know about the drugs being used most frequently today, for example, cocaine.\textsuperscript{6}

2.2.5 Program Participants

The most extensive needle exchange program evaluation study done to date, one by Lurie,\textsuperscript{11} provides evidence of the variation in demographics associated with needle exchange participants. Clearly, injection drug users are a heterogeneous group.\textsuperscript{56,70}
Overall, needle exchange programs predominantly attract males, while women remain underrepresented in both Canada and the United States. Program attenders tend to be unemployed, living on social services and lacking stable housing. While education levels vary, most participants have lower levels of education than the general population. A large proportion have a history of incarceration. Many clients have been in treatment for addiction and many, from both sexes, report risky sexual behaviours.

2.2.6 Harm Reduction Strategies

The underlying tenet of most needle exchange programs is harm reduction. Harm reduction is a pragmatic approach to drug use that focuses on reducing some of the harmful effects associated with that use. It is based on several complementary solutions operating simultaneously to reduce risk. The emphasis is on the more attainable short-term goals over long-term goals. Harm reduction does not condone nor condemn drug use, but accepts that drug use continues and that initiatives can be taken to minimize the harm associated with it. Many of the harms incurred by illicit drug use result not so much from the use of drugs, but rather from the social marginalization and stigmatization associated with it.

2.2.7 Ethical Considerations of Injection Drug Use

The development of needle exchange programs has not been without controversy. Opponents of needle exchange programs argue that establishing this type of service appears to condone illicit drug use and will undermine the ‘war on drugs.’ They claim
that providing sterile needles to injection drug users will lead to an increase in the number of new injection drug users and eventually, to an increase in the number of AIDS cases. Further, they argue that multi-person use of needles is not necessarily eliminated by needle exchange programs.\textsuperscript{40}

With the public health crisis surrounding HIV infections, both public health and community well-being are at stake until some common ground is found to establish ways to effectively reduce HIV and other blood-borne pathogens in the injection drug-using population.\textsuperscript{3} The Canadian Task Force on HIV and Injection Drug Use suggests that it is, "time to move beyond debating ideological differences and take full advantage of the knowledge and experience already available."\textsuperscript{2(p.10)}

2.2.8 Summary

Needle exchange programs evolved in response to the increased prevalence of HIV and other blood-borne pathogens. They did not emerge as a single intervention strategy, but rather as part of a more comprehensive harm-reduction approach to prevention. The rationale for these programs is simple: HIV is spread through blood products; needle sharing puts people who share at risk, and providing sterile needles and injection drug equipment to high-risk groups of injection drug users can reduce their need to share. Other services usually provided in addition to needles are counselling, education, support referrals, condoms, and containers for used equipment.

Needle exchange programs are as diverse as the injection drug populations that they serve. There are many different types of needle exchanges generally falling under
two categories: fixed or mobile. Hours of program operation vary according to need, location, and resources. Staff may be health professionals, social workers, outreach workers, or former ‘street’ people. Policies usually incorporate a one-to-one exchange and some programs still have a quota on the number of needles that one client can exchange in a day.

Needle exchange participants vary in terms of their demographic characteristics. In general, needle exchange clients tend to be males, with lower education levels than the general population, who are unemployed, living on social services, and have a history of incarceration.

Potential benefits of needle exchange programs include: provision of sound health information and referrals to drug treatment, as well as a network of support for behaviour change. The decrease in HIV transmission among injection drug users is difficult to determine. In some cities the seroprevalence rates of HIV have been higher, which may indicate that needle exchange programs are reaching extremely high-risk people.

Despite the fact that needle exchanges have emerged in many developed countries, controversy still exists because of their association with illicit drug use. Ethical or moral arguments from various viewpoints continue to be heard.

2.3 Evaluation Studies

There have been many studies evaluating needle exchange programs or the needle exchange service within street outreach programs. All the pilot programs in Canada
receiving federal funding in the late 1980's had to incorporate a means of evaluation before they received funding. Some centres have done further evaluations since that time (e.g., Calgary, Edmonton, Vancouver), and others have not.

Studies evaluating needle exchange have been prone to a variety of limitations. Inadequate samples, inappropriate control groups, sample attrition, and incomplete analysis have been documented frequently.\textsuperscript{3,65,75} Other limitations include self-reported data collection, problems with validity, and an inability to separate needle exchange effects from other program components.\textsuperscript{75}

This section will summarize the process and impact evaluations carried out in Toronto, Montreal, Calgary, and Edmonton. The evaluations are able to be compared because they all used the questionnaire developed by the World Health Organization (WHO) collaborative group, or an adapted version thereof. Emphasis will be placed on the Western Canada studies. Finally, a brief summary of the University of California report reviewing the effectiveness of 33 U.S. and Canadian needle exchange programs will be presented.

### 2.3.1 Toronto

Toronto's \textit{The Works} was established in 1989 by the City of Toronto Department of Public Health to prevent transmission of HIV among injection drug users in that city. It was one of the federally funded pilot programs. The objectives of the initial evaluation were: i) to get detailed information on sexual and drug use behaviour of injection drug users not in drug treatment; ii) to attempt to follow as many injection drug users as
possible at three-month intervals to assess behaviour change; iii) to establish an HIV seroprevalence baseline.\textsuperscript{71}

This evaluation design used interviews with 582 injection drug users to assess the sociodemographic information of their clients in addition to client satisfaction with the program. Seroprevalence was determined by a saliva and blood (finger prick) sample. Follow-up interviews after a three month period were completed on 95 injection drug users. Comparisons between program attenders (clients) of \textit{The Works} and non-attenders (recruited through poster advertisements) were made on demographic and behavioural characteristics.\textsuperscript{76}

Data from program impact provided valuable information on program utilization and referrals made to drug treatment and other services. There was no increase in the number of needles used by program attenders, and there was a decline in needle sharing. The number of clients who cleaned their needles with bleach also increased. Data did not show improvement in risk behaviours associated with sexual practices, except that consistent use of condoms with casual partners increased.\textsuperscript{71}

The strength of this study is that a very large number of injection drug users was sampled. The major weakness is that the representativeness of the sample is uncertain.\textsuperscript{71}

2.3.2 Montreal

\textit{CACTUS}-Montréal is a fixed site in downtown Montreal, Quebec. It has been in operation since July 1989 and was one of the eight pilot programs.

There have been two research studies providing needle exchange participation
The first is a formal attempt to evaluate the effect of the needle exchange program on risk behaviours, HIV prevention and incidence. The second is a prospective epidemiologic study among injection drug users initiated prior to the CACTUS program.

This study has reported meaningful reductions in risk behaviours among needle exchange attenders compared to non-attenders. High incidence rates of HIV could be a result of the program attracting high-risk groups. Selection and sample biases exist so that causal inferences about the effect of the needle exchange on risk behaviours and HIV prevalence and incidence are more difficult to establish.

2.3.3 Calgary

Calgary’s needle exchange program was established in 1989 and is currently part of the Injection Drug Education and Prevention Program (IDEPP). The program consists of a fixed site, Calgary Urban Project Society (CUPS), situated in downtown Calgary, and a mobile van. The initial evaluation was conducted over a two-year period. Three hundred and six injection drug users were interviewed in four cohorts (1991, early 1992, late 1992, and early 1993). Comparisons were made between data collected from the 85 respondents who returned for a second interview and the 251 individuals who had not returned by May 1993. Key findings included valuable information on client characteristics, satisfaction with the program, and program impact (e.g., program was primary source of needles for clients, return rate of dirty needles increased consistently, borrowing and lending of needles decreased).

Limitations with this evaluation study were due to recall and reporting biases.
Analysis was dependent upon self-reported data from injection drug users.

The latest evaluation reported the findings from one hundred interviews with program users, conducted in February 1997. Various aspects of demographic information and drug use profiles of program clients, utilization, client satisfaction, knowledge about HIV/AIDS, and risk behaviours associated with transmission of HIV were described. Key findings indicated that client characteristics remained similar to those in 1993, with the exception that more females accessed services, and the fact that the majority of clients used cocaine and most injected every day. Condom use was high among those with high-risk sexual behaviours.79

2.3.4 Edmonton

Edmonton’s needleworks began operating in August 1990.80 Today, Edmonton has approximately 1900 clients and the name has been changed to Streetworks, which better reflects the mandate of the program.81

The initial evaluation utilized a collaborative approach between the coordinating committee and the evaluators. Three hundred and forty interviews with program users and non-users were conducted over a two-year period.80

Streetworks designates an annual budget for evaluation and several have been conducted over the years. In recent years, more ethnographic studies have been done. In 1996-97, the evaluators focussed on two key areas: program development support and program outcomes. Program development support included revising the program conceptual model, designing and implementing a better system for collecting program information.
statistics, and transferring responsibility for program statistics to a participating agency.

Program outcomes included analyzing utilization rates and patterns in a historical prospective, attempting to learn what difference Streetworks makes for clients, and naming practices that contribute to client-defined outcomes.81

Data revealed that client demographic profiles have remained stable. The program has not been able to reach young members and certain cultures (e.g., Asian) of the target group; the program has been able to reach Aboriginal and Caucasians, and a large number of pregnant street-involved clients. The median number of needles collected and disposed of was greater than the number distributed. The number of both needles and condoms distributed has been increasing. Nursing services were perceived to be a valuable part of the services delivered.81

2.3.5 University of California Report

The University of California report resulted from a multi-disciplinary team which used multiple-method data collection (e.g., formal review of existing research, site visits and surveys of needle exchange programs, focus groups with injection drug users) to assess needle exchange programs, in the US, Canada, and Europe. Fifteen sites including 10 in the US, 3 in Canada, and 2 in Europe were visited and multiple data collection methods (e.g., interviews, observations, focus groups) were used.311

The panel examining the evidence on the effects of needle exchange programs from the University of California and multiple sources concluded:

1. Needle exchange programs increase the availability of sterile injection
equipment.

2. Increased availability of needles reduces contaminated needles in circulation.

3. The lower the fraction of contaminated needles, the lower the risk for new HIV infections.

4. Other possible positive outcomes reported by users of needle exchange programs include:
   1. increased cleaning of used needles;
   2. decreased sharing of needles;
   3. uncertain or small improvements in risky sexual behaviours (fewer partners, increase in condom use).

5. Needle exchange programs report increased referrals to drug treatment services and in a few studies, no increase in the number of dirty needles being discarded in public places.

6. Available scientific literature provides evidence based on self-reports that needle exchange programs:
   1. do not increase the frequency of injection among attenders;
   2. do not increase the number of new initiates to injection drug use;
   3. have public support, depending on locality;
   4. have public support that tends to increase over time.3,11

2.3.6 Summary

Many evaluations of needle exchange programs have been carried out. For the most part, scientific evidence to support their effectiveness in containing new HIV infections has not been forthcoming, largely due to problems in research design. Research limitations usually include sampling biases, lack of true comparison groups,
and data based on self-reports.

In Canada, many of the initial pilot programs conducted process and impact evaluations as required for their funding. Process indicators used for measurement included: i) increase in the number of needles distributed, ii) increase in the number of condoms distributed, iii) increase in the number of referrals, iv) building relationships with clients, v) determining needle exchange rates. Other measures included the number of clients served, numbers of needles given out and returned, client characteristics (age, sex, drug use, needle sharing, reasons for sharing, frequency of injections, gender of sexual partners) and client satisfaction with the program. All pilots used a questionnaire developed by the WHO collaborative group for ease of comparison. Some sites measured program impact by following individuals over time and examining self-reported behaviour change and repeated measures of their HIV status.

Findings from these initial evaluations were based on a large number of clients and results indicate a decrease in self-reported risk behaviours associated with drug use among program attenders. Many clients were able to access substance abuse services for the first time, and data provided evidence that needle exchange programs have not led to an increase in drug use among injection drug users. Findings did not provide conclusive evidence that needle exchange programs result in a decrease in the number of new HIV infections.

Evaluations of the pilot programs have demonstrated the importance of collecting some basic process measures that should be systematically collected at the program level. These data are needed to monitor and defend prevention efforts. Impact and outcome data would be difficult to interpret without this valuable information.
3. METHODS

This study evaluated the risk reduction component of the Street Outreach program, focusing on needle exchange, which is the largest activity or service in that component. Injection drug-using clients registered with Street Outreach participated in a client survey which provided information on client demographics, their injection and sexual practices, their knowledge about blood-borne and other sexually transmitted diseases, and their perceptions of the Street Outreach services. I also talked to the staff and observed aspects of service delivery from the van, including the provision of needle exchange, condom distribution, health information, and client referrals. Limited information was also collected from a review of statistical, inventory, and summarized management records.

This section describes the collaborative approach taken in this evaluation, the setting, study design, study population, data collection methods and procedures for each of the research objectives, as well as reliability and validity issues, ethical considerations and data analysis.

3.1 A Collaborative Approach To This Evaluation

Collaboration between the researcher and the organization is an important aspect of program evaluation. This evaluation study involved collaboration with the management team of Public Health Services and the Street Outreach staff. The intent was to encourage an interactive, collaborative way of evaluating the program, based on
the assumption that people support what they are involved in. Although this is important in any evaluation, it is particularly so in this case. The department manager and the Medical Health Officer (MHO) were instrumental in providing direction and focus for the evaluation objectives in addition to providing support, both by way of resources and encouragement for the project. The MHO's expertise in the area of HIV and sexually transmitted diseases was helpful in formulating specific survey questions and in determining what PHS needed to know about the clients in the program. Staff were not only instrumental in recruiting clients for the survey, they were also willing to be trained as interviewers to assist in data collection.

Given the time frame for the evaluation, I was unable to use a participatory approach with the clients. A participatory approach is extremely time-consuming, although potentially very effective in gathering client input and effecting change.84

Initially, I met with members of the management team to discuss the focus of the evaluation. Discussions over a period of six months resulted in the selection of process indicators to be used in this evaluation. The approach began with a brainstorming session around questions that needed to be answered within the Sexual Health program component, particularly to do with Street Outreach and needle exchange. The questions were grouped into three categories for ease of further discussion: stakeholders (e.g., other agencies or individuals with an interest in the program), staff, and clients. Questions were redefined and specified within each category.

We reviewed the questions to establish whether or not they could be answered by data collected on an on-going basis or by special survey. Once that was determined, we prioritized the most important questions to be answered at this time and indicated who...
could best answer them. As a result of this process, highest priority was given to questions concerning Street Outreach clients, client satisfaction and the needle exchange service. These questions thus formed the basis for the research questions, defined what should be measured within each, and resulted in specific process indicators which were used as measures for each of the questions.

Edey and Newton emphasize that, “In order to support both continuous improvement and accountability, we all need to create and communicate information.” The intent of this evaluation was to facilitate creation and communication of information for the purpose of improving the services in the risk reduction component, particularly needle exchange.

3.2 Setting

Two part-time (.75 full-time equivalent) outreach workers and one full-time nurse provide the Street Outreach services. These services include one-to-one counselling, referrals and provision of the materials for prevention of sexually transmitted diseases, HIV and hepatitis B and C (condoms, bleach, needles, safety containers for needles). Services are provided to street-oriented youth, sex trade workers and their partners, and injection drug users and their partners – all of whom are considered to be clients. Services are delivered on the street and in neighborhood locations, with the office based at Public Health Services on Idylwyld Drive North, Saskatoon. The majority of the needle exchange service is provided from the mobile van. Clients are encouraged to make arrangements with the program staff for needle exchange. Since the addition of a cellular phone approximately two years ago, clients are able to call the staff and arrange
for needle exchange at a mutually agreed upon place, often just outside their homes.

As discussed earlier, other services provided by Street Outreach include health/education, support and advocacy, referrals, condom distribution, and nursing services, which include anonymous HIV testing, hepatitis B and C screening, and hepatitis B immunizations. The nurse from Street Outreach also provides anonymous HIV testing at the Saskatchewan Correctional Institution and at Kilburn Hall, a correctional institution for youth.

In 1997, Street Outreach and an inner-city pharmacy formed a partnership which allows the pharmacy to exchange sterile needles. The location of the pharmacy and the extra hours extend service to injection drug users in the community. As explained earlier, the STD clinic also does needle exchange during clinic hours.

Program hours were designed to reflect client needs. The hours of operation for the mobile van are 8:00 p.m. to 12:00 midnight, Monday through Friday with the exception of Wednesday, when the staff is available from 2:00 p.m. to 6:00 p.m. The daytime hours were added in 1997 to allow the staff more time during regular business hours and more visibility in the inner-city communities and schools. Staff, however, work additional daytime hours to make up their full-time equivalencies. They rotate on a three-week schedule which ensures that all staff work daytime hours every third week. In the evenings, two staff work in the van at all times for safety reasons.

Staff turnover has been considerable. The nurse working with the program has been with PHS for two years. She has a background in northern nursing and considerable experience working with Aboriginal people. One of the outreach workers, recently hired in a permanent position, has a background in community development and sociology.
She had been acting in a temporary position with Street Outreach for the past two years, and so is familiar with the clients and program operations. The second outreach worker has a background in social work and has been with the program since 1993. She was on an education leave for most of the evaluation period doing a practicum with a substance abuse program in Scotland. She was replaced by an outreach worker who had worked in a similar street outreach program in eastern Canada. All the staff have considerable experience in working with the Street Outreach target group.

Until recently, staffing for Street Outreach was problematic because there were no casual staff assigned to the program. As a result, replacement for illness and vacation was difficult. To address staffing problems associated with illness and vacation, two nurses working part-time in the Sexual Health program have been orientated to Street Outreach. They work as casual replacements when needed. The outreach worker hired to replace the worker on education leave has continued to work on a casual basis.

3.3 Design

This is a descriptive evaluation design. By definition, a process evaluation is a descriptive study. Patton emphasizes that "a focus on process is a focus on how something happens rather than on the outcomes or results obtained."\(^{13}\) Process evaluations are aimed at elucidating and understanding the internal dynamics of a program, describing program activities, identifying who the program is reaching, determining the quality of service, and assessing client satisfaction.

The majority of Street Outreach clients are injection drug users. The intent of this evaluation was to determine who the needle exchange service was reaching, their
perceptions of the service, and how service was being delivered. It did so according to the three research objectives previously identified.

Table 3.1 is a duplicate of Table 1.1. It shows the relationship between the research objectives and sub-objectives, and process indicators for the risk reduction component.

Data collection will be addressed in section 3.5.
<table>
<thead>
<tr>
<th>Research Objectives</th>
<th>Process Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. To describe aspects of service delivery</strong></td>
<td>- description of aspects of service delivery</td>
</tr>
<tr>
<td>1.1 To describe needle exchange</td>
<td>- # needles issued &amp; returned</td>
</tr>
<tr>
<td>1.2 To describe condom distribution</td>
<td>- # condoms distributed</td>
</tr>
<tr>
<td>1.3 To describe health information given to clients</td>
<td>- identify types of health information given to clients</td>
</tr>
<tr>
<td>14 To describe client referrals</td>
<td>- # clients referred</td>
</tr>
<tr>
<td>1.5 To describe testing, immunizing</td>
<td>- establish where clients are being referred</td>
</tr>
<tr>
<td>1.6 To describe resources for service delivery</td>
<td>- # clients tested</td>
</tr>
<tr>
<td>2. To describe the Street Outreach clients who are injection drug users &amp; their risks for HIV, other blood-borne infections &amp; sexually transmitted diseases</td>
<td>- # clients immunized</td>
</tr>
<tr>
<td>2.1 To document # clients using needles</td>
<td>- # clients testing positive</td>
</tr>
<tr>
<td>2.2 To describe client sociodemographics</td>
<td>- # staff, staff qualifications, resources, funding</td>
</tr>
<tr>
<td>2.3 To describe clients’ injection practices</td>
<td></td>
</tr>
<tr>
<td>2.4 To describe clients’ sexual practices</td>
<td></td>
</tr>
<tr>
<td>2.5 To describe clients’ knowledge of HIV, Hepatitis B&amp;C, and sexually transmitted diseases</td>
<td></td>
</tr>
<tr>
<td>3. To describe clients’ perception of the Street Outreach service</td>
<td>- description of clients’ perception of service (e.g., utilization &amp; accessibility, satisfaction with services)</td>
</tr>
</tbody>
</table>
3.4 Study Population

Primary data were collected from two groups: staff from the Street Outreach program and clients who were injection drug users.

3.4.1 Staff Participants

Observations were used to supplement and verify descriptive information from other sources in order to meet the first research objective. I observed all three Street Outreach staff providing service from the mobile van. Consent to observe staff providing service activities was obtained from the Public Health management team and the staff (see Appendix B).

As explained in Section 3.2, all three program staff provide direct service and rotate between working daytime and evening hours. All evening hours are spent in the mobile van providing direct service to clients and the majority of that time is spent doing needle exchange. Since I wanted to focus on service delivery from the van, I felt that I should observe all staff providing service from the van in case the person delivering service influenced the delivery.

3.4.2 Client Participants

A convenience sample of injection drug-using Street Outreach clients, registered with the program, served as the participants for the study. Participation was voluntary. To improve interviewing conditions, trained program staff and myself were available at the STD clinic during the first week of the study period (February 9 - 13, 1998) for the
specific purpose of administering the client surveys. Subsequent interviews were done both in the van and at the STD clinic when staffing permitted. Administering the surveys at the STD clinic eliminated the difficulties encountered when interviewing in the dimly lit van at night.

Sample

There are three sites where clients can access needle exchange: the mobile van, STD clinic and Hewgill’s Pharmacy. A few clients get their needles from only one site; others use a combination of sites. Most needle exchanges occur in the van. To increase the representativeness of the sample, invitations to participate were issued to clients at all three sites.

There are many formulas available to determine sample size. As a guideline to the minimum number of clients to enroll, a 90% confidence interval for sample size was used according to the following formula: \( \chi^2 NP(1-P)/[C^2(N-1)+P(1-P)] \) where \( \chi^2 \) is chi-square at one degree of freedom at some desired probability level (in this case, 90%); \( N \) = population size; \( P \) = population parameter of a variable; and \( C \) is the confidence level chosen. Based on 1996 data with a population of 304, a sample size of 69 was needed to meet this requirement. Since sufficient funding was available to enroll 100 clients during the study period (February to May, 1998), we decided to aim for this number.

Eligibility for Client Survey

Eligibility criteria for the client survey included all clients who were registered with Street Outreach or clients known by the program staff who:

- were injection drug users (currently or within the past six months)
- self-selected to be a participant in the survey
• spoke English, and
• did not appear to be so intoxicated or high at the time of the interview that they were unable to be interviewed.

In order to increase the number of participants willing to participate in the study, each participant was given $20.00 after completion of the questionnaire. Those clients not already registered with the program by January 1998 or unknown to the program staff were not allowed to participate, in order to deter injection drug users who were not clients from participating just for the money. Public Health Services, Healthy Lifestyles Department provided $2,040 in funding to pay respondents for participating. I provided an additional $20.00 in order that one more interview could be conducted to replace one that did not fit the criteria.

Recruitment

Prior to the evaluation, program staff verbally informed clients of the study and the requirement that they needed to know their client registration number in order to be included in the survey. The numbers were used to verify that individuals were indeed Street Outreach clients.

A short information card telling the clients how they could participate in the study was prepared (see Appendix C). It provided them with a telephone number and address for more information about the study. This card was given to clients accessing needles at all three sites. Program staff also distributed the card to eligible clients when contact was made, even if the clients were not accessing needles at the time.
3.5 Data Collection

3.5.1 Role of the Researcher

I have worked as a public health nurse in the Sexual Health Program at Public Health Services for the past five years. During that time I have had the opportunity to talk with several injection drug users in a professional capacity. As a result of these many encounters, I have become familiar with the issues around injection drug use. For this reason, I have certain knowledge and insight that I did not gain directly from data collected for this study. I refer to this as knowledge gained from my own professional experience and have documented it as such in this report.

The situation just described also put me in a unique position to evaluate the Street Outreach project. Being familiar with the project, but not working in it or directly with the staff has put me in a good position to be objective, even as an internal evaluator, yet well-informed and comfortable with the clientele.

3.5.2 Data Collection Methods

This evaluation study depended on three methods of data collection to meet the objectives of the study: i) observation and discussions with staff; ii) client survey; and iii) review of statistical, inventory, management and program records.

Observations and discussion with staff, statistical data, policy and procedure protocols and inventory records served as the data sources to satisfy the first research objective, describing aspects of service delivery. For the observations, program staff delivering service during the study period served as participants. Both client statistical
data and clinic statistical data collected by program staff on clients in 1997 served as additional data sources, as did condom and needle inventory records kept for 1997.

A client survey served as the primary data collection source to satisfy the second and third research objectives which were concerned with describing the injection drug using clients, their risks, and their perceptions of Street Outreach services. All registered Street Outreach clients or clients known to the program staff who were injection drug users or had been within the past six months served as the population for these two research objectives. Client statistical records kept by the program staff served as a secondary data source for one process indicator.

Inventory and management records from 1997 served as the data sources for describing the resources needed for Street Outreach programming, which is research sub-objective 1.6.

Table 3.2 shows the relationship between process indicators and data sources.
Table 3.2  Relationship between process indicators and data sources

<table>
<thead>
<tr>
<th>Research Objective</th>
<th>Process Indicator</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Describing aspects of service delivery.</td>
<td>- # needles exchanged</td>
<td>Client statistical records and protocols; inventory records</td>
</tr>
<tr>
<td></td>
<td>- # condoms distributed</td>
<td>Client statistical records and protocols; inventory records</td>
</tr>
<tr>
<td></td>
<td>- types of health information given to clients</td>
<td>Observations and discussion with staff; Client survey (#63)</td>
</tr>
<tr>
<td></td>
<td>- # client referrals</td>
<td>Client statistical records and protocols; observations and discussion with staff</td>
</tr>
<tr>
<td></td>
<td>- where referrals are being made</td>
<td>Clinic statistical records; client survey #57, 60</td>
</tr>
<tr>
<td></td>
<td>- # clients tested</td>
<td>Clinic statistical records; client survey #61</td>
</tr>
<tr>
<td></td>
<td>- # clients immunized</td>
<td>Clinic statistical records</td>
</tr>
<tr>
<td></td>
<td>- # positive tests</td>
<td>Inventory and management records</td>
</tr>
<tr>
<td></td>
<td>- # staff; staff qualifications; description of resources; funding</td>
<td></td>
</tr>
<tr>
<td>1.6 Resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Describing injection drug using clients’ sociodemographics, injection &amp; sexual practices, knowledge of HIV, hepatitis B and C, STDs</td>
<td>- # clients using needles</td>
<td>Client statistical records</td>
</tr>
<tr>
<td></td>
<td>- description of sociodemographics</td>
<td>Client survey (#1-9)</td>
</tr>
<tr>
<td></td>
<td>- description of injection practices</td>
<td>Client survey (#10-38, #52; #56)</td>
</tr>
<tr>
<td></td>
<td>- self-reported condom use</td>
<td>Client survey (#39-41; 49-51)</td>
</tr>
<tr>
<td></td>
<td>- description of knowledge related to HIV, hepatitis B&amp;C, STDs</td>
<td>Client survey (#42-48)</td>
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<tr>
<td></td>
<td></td>
<td>Client survey (#53-59)</td>
</tr>
<tr>
<td>3. Describing client perceptions of satisfaction with Street Outreach services.</td>
<td>- description of client perceptions of Street Outreach services</td>
<td>Client survey (#62-70)</td>
</tr>
</tbody>
</table>

3.5.2.1 Observations and Discussion with Staff

Observations of Street Outreach staff providing service and discussions with staff were used as the principal data sources to satisfy the first objective: to describe some aspects of service delivery provided in the van. I observed program staff to describe how
they provided needle exchange, distributed condoms, provided health information, and made client referrals. I was unable to observe the nurse providing testing and immunizing because the opportunity to do so did not present itself during the observation period. I observed the staff providing service in the van for a total of 28 hours, on 7 different occasions in March and April. I was able to go out with each staff member at least twice. On each occasion, I drove the van.

I prepared a simple protocol to follow which allowed me to direct my observations and record them as field notes (see Appendix D). I recorded pertinent basic information (e.g., where the observation took place, the people present, what social interactions occurred, and what activities took place) as well as my own feelings and reactions to what I observed. Informal discussions with the program staff served as an additional source of information to clarify and elaborate on my observations.

Observation data in this evaluation study were secondary to the information from the client survey. There was no attempt to make the observation a systematic collection of data except to describe the program setting, physical and social environments, nature of the interactions between program staff and clients, and some of the activities that were observed according to the protocol established. Observation was a qualitative method to help explain the quantitative data collected from the client statistical records and client surveys. Patton suggests that observations should last as long as it takes to answer the research question and to fulfill the purpose of the study, both of which are dictated by the time and resources available, and the needs of the information users. These criteria were used as a guide in this evaluation study.
3.5.2.2 Client Survey

The client survey provided most of the data for this evaluation.

Survey Instrument

Process evaluations conducted by several of the first needle exchange programs in Canada used an adapted version of a questionnaire developed by the WHO collaborative group on HIV/AIDS. The questionnaire had been used in comparative studies of drug injecting behaviour and HIV infection in 13 international studies and subsequently as a data collection tool in several needle exchange program evaluations. Since that time, many questions have been deleted to make the questionnaire shorter. Recently other questions were added based on new information that has been gathered about client characteristics and risk factors associated with HIV and other blood-borne pathogens.

The questionnaire used in this evaluation to describe clients’ characteristics and their sexual and injection risk practices contains questions from the Cape Breton survey, which is a recently adapted version of the original WHO collaborative group questionnaire. There are both closed- and open-ended questions. The survey was developed to be administered by trained interviewers.

The questions selected from the Cape Breton survey to be used in this study were those which reflect client demographics (questions # 1-9), injection risk practices (questions # 10-38), and sexual risk behaviours (questions # 39-51). I modified some of the questionnaire items in order to reflect our own situation (e.g., “How long have you lived in Saskatoon?”). Question #23 was added to get more information regarding potential clients that are not being reached and to get information on secondary
distribution rates. Also added was question #53 on STD symptoms, #55, on means of HIV prevention, and #56, on clients’ perception of risk for HIV.

I modified questions pertaining to client satisfaction (#62-70) from an evaluation conducted this past year by the Injection Drug Education and Prevention Program in Calgary. I made some of the questions open-ended to allow clients to generate their own thoughts about what they liked or did not like about the service. Likert scales were added to others in order to get a better indication of satisfaction or dissatisfaction.

Due to time constraints in training program staff to interview, limited probing was used in administering the questionnaire. Neutral probes, such as repeating the question when the respondents did not seem to understand, were used. Other probes were written directly on the questionnaire for the interviewers to follow. After the first few interviews, we included the phrase ‘even your partner’ for Question #17a because it was apparent that respondents were not considering their partners when answering this question.

I pretested the questionnaire used in this study with STD clinic staff and ten people from drug and alcohol treatment centres in Saskatoon who were typical of the Street Outreach needle exchange clients. Pretesting the questionnaire was helpful in confirming the time needed to administer it, in addition to improving the clarity and flow of the questions being asked.

Two questions were added after pretesting the questionnaire. These both related to awareness of certain aspects of the program, for example, needle exchange at Hewgill’s Pharmacy and how clients initially heard of the needle exchange service.
The questionnaire is found in Appendix E. It was administered to the study participants by myself and Street Outreach staff whom I trained to assist me in conducting the interviews. Training procedures are described in Section 3.6, Reliability and Validity Issues.

Procedure

Registered Street Outreach clients who agreed to participate in the study were informed about the nature of the study, how long the questionnaire would take to administer, how the information would be used, and the potential benefits of their participation (personally and to the agency). Participation was voluntary and implied consent. To protect anonymity, a written informed consent was not obtained. A consent checklist was reviewed with each client prior to the interview, signed by the interviewer and dated. The participants were offered a card with my name and telephone number after the questionnaire was completed. The same procedure was used when registered clients self-selected to be survey participants by coming to the STD clinic during the study period.

Although clients were told that they needed to know their registration numbers in order to participate in the interview, many presented at the STD clinic during the first week of the study to be interviewed without knowing their numbers. One of the program staff was given extra hours in order to help me determine whether or not the people who came without knowing their numbers were truly registered clients in the program. If the people did not know their numbers or were unknown to the program staff, they were not considered eligible to participate in the survey. However, the program staff were able to
register them with the program and as a result, new injection drug users became Street Outreach clients.

To ensure privacy, survey participants at the van were offered a seat inside the van during administration of the questionnaire. If two people were being interviewed, one client and an interviewer sat at the back of the van while the other client and the second interviewer sat in the front seats of the van. In the STD clinic, a private room was used with only the interviewer and the client present. In the case of some clients who were well-known to the staff, interviews were conducted in their homes at their request.

Special consideration was given to the safety of the staff during data collection in the mobile van. Given that at least some of the data collection occurred in a ‘street’ environment, at night, the agency’s policy on safety was followed. Precautions included, for example, carrying a cellular phone, always having two people (one interviewer and one staff member) present, and not carrying more than $60.00 at any time.

Client confidentiality was maintained by using only trusted program staff and myself to administer the questionnaires. Identification numbers were used instead of names and recorded only in a special book which provided a means of accounting for the money from PHS to pay participants. When clients received the payment for participating, the interviewer initialled the book, verifying the date the survey was done, the client identification number, and that the client had been given $20.00. No client identification indicators were recorded on the surveys.

All clients were instructed at the beginning and during the questionnaire that if they felt uncomfortable answering any of the questions, they were not required to answer
all the questions in order to receive the $20.00; however, if they chose to withdraw from the survey before the interviewer finished the questionnaire, they were not eligible to receive payment.

Data sources for the second research objective and sub-objectives are mainly from the client survey. In total, 100 interviews were conducted by myself and the program staff from February 9 to May 7, 1998. A total of 103 interviews were conducted, but two were discarded because they were duplicates and the third because the respondent did not satisfy the criteria. Only one client refused to answer one of the survey questions and everyone who started the survey completed it.

The interviews were conducted in the mobile van, the STD clinic and at clients' homes. A total of 55 interviews were conducted in the mobile van and 45 in the STD clinic. Those conducted in clients' homes were counted as interviews in the van. As principal investigator, I conducted 42 interviews, while the remainder were distributed among the three staff.

3.5.2.3 Program Records

Four types of program records were reviewed: statistical records kept by the program staff, policy and procedures for Street Outreach, inventory and management records. These records were used as data sources for the first research objective.

Statistical Records

Daily statistical records kept by the Street Outreach staff provided further data on clients. Street Outreach staff keep daily statistics (Appendix F) which were designed to
document the number of individuals assessed and receiving service. The intent of this record was to provide process information, documenting program activities. All contacts made with clients were to be documented according to their client registration numbers. A contact is a single interaction with a client. It could include providing information on any topic, providing condoms to a client, or a one-to-one counselling session with a client. Staff record on the statistical form which clients make contact, the method of contact (e.g., home visit, van, phone), the number of needles given to each client and the number returned, the number of condoms distributed, type of referrals made, and type of counselling (e.g., pregnancy, addiction) provided.

Although the staff record this information, there is no consistency in the information being recorded and some of the information is the staff’s best guess (e.g., client’s age, ethnicity). There are guidelines and definers for each of the categories to be documented on the statistical forms, however, they are vague and generally too broad.

The current form was enlarged recently to allow for more practical means of data collection in the van, but it still does not record appropriate information about the clients. For example, there is a client profile section on the daily statistical form, but it is not being used. The clients’ lifestyle risk factors for HIV, hepatitis B and C, and STDs are not recorded.

Because the daily statistical form is difficult to use and staff are busy, often it is not completed in a timely fashion. As a result, data are not being entered on the computer database in time to provide management with information for program planning or decision-making. In preparation for this evaluation, many problems with the
way data were being recorded became obvious. As a result, only certain data from the statistical records were used for this evaluation and they were considered secondary to the data obtained from the client survey.

There is some information that has been recorded reliably on the daily statistical form and this information was used in this evaluation. Data about client contacts and client registration numbers, the number of needles, condoms distributed, and the number of referrals and who the referrals are made appear to be accurate and were used. Whenever possible this information was used to validate data gathered from other sources.

Other clinic statistical data are kept by staff in the Sexual Health program and information pertaining to Street Outreach clients is documented on those records. For example, when the Street Outreach nurse tests a client for HIV, a number is recorded on the same form used by the nurses at the STD clinic who do anonymous HIV testing. The number of tests done by Street Outreach is compiled monthly by one of the nurses in Sexual Health who has the responsibility for compiling all the clinic statistical data.

A different record is kept for hepatitis B and C testing. This record documents the client’s name, date of birth, the testing done, the results and the nurse’s initials. It is tallied by the same nurse completing the anonymous HIV statistics for the Sexual Health program. This information is not broken down into the number of tests done by the Street Outreach nurse or other clinic staff, although the information could easily be computerized which would make it easier to access for evaluation purposes.

When a client is immunized (e.g., against hepatitis B) by the Street Outreach
nurse, each immunization is entered into a database kept by the Disease Control Department. Each month the nurse receives a line-listing for all the clients who have received the first or second dose of a three-dose series. Once the immunization series is completed, no other computerized record is kept. Information has to be retrieved manually from records kept by the nurse, or from the client’s chart which is kept with other client charts in Sexual Health.

Policy and Procedures for Street Outreach

The policy and procedures for Street Outreach were developed when the needle exchange program began. It was dated February 1993 and provided guidelines for providing service and operating the van. It addressed program delivery, condom distribution, needle exchange, transportation and storage of needles and client referrals. There were protocols for police contact, statistical information and staff safety. These protocols were reviewed for comparison to how service is currently being delivered.

Inventory and Management Records

The staff nurse in the Street Outreach program is in charge of ordering the needles and some of the condoms (e.g., Ramses brand) distributed to clients. She keeps an account of the number of needles and other supplies, such as bleach and disposal containers, that are ordered and the amount actually received. The same type of account is kept for Ramses condoms. The manager of the Healthy Lifestyles Department is in charge of budgeting these supplies, but currently they are not costed out to the project area. For example, the amount of money budgeted for condoms and the number of condoms bought for the Sexual Health program is known, but a record is not kept.
separately for the number used by Street Outreach, except for the Ramses brand. Street Outreach staff do record the number of condoms distributed from the van on the daily client statistical form. In this study, the information from the inventory records was used to validate the number of syringes and condoms distributed by Street Outreach recorded on the statistical data sheets kept by program staff during the 1997 calendar year.

Finally, the department manager provided me with the information I requested in order to be able to document the resources required for the Street Outreach project. The budgeted amounts spent on supplies and resources, for example, gas for the mobile van, were summarized for evaluation purposes.

3.6 Reliability and Validity Issues

The Street Outreach nurse, the two Street Outreach workers, and I administered the client questionnaires. There were difficulties using traditional research methods with this population. For example, the test-retest method of checking instrument reliability was not appropriate. Since respondents typically have problems with recall related to their drug use, it would have been difficult to assess whether the differences noted between test periods resulted from an unreliable instrument or from the respondents' inability to answer questions about times when they were under the influence of psychoactive drugs. To minimize recall bias, clients were asked about practices restricted to the last six months.

To minimize interviewer bias, I trained the Street Outreach staff to administer the client survey. As part of their training, one interviewer administered the questionnaire
while the others observed and independently recorded the participant’s answers. The answers were compared for reliability as a function of agreements using the following equation:

\[
\text{number of agreements} \div \text{number of agreements} + \text{number of disagreements}\]  

(3.1)

in order to assess interrater reliability. Because the questionnaire data were describing individuals, I wanted the reliability of agreement to be at least .90 among all interviewers. Training and practice interviewing continued until this level was reached for each interviewer. The final interrater agreements for the interviewers ranged from .94 to 1.00.

Face validity was maximized by having expert researchers knowledgeable in the area of HIV/AIDS from different countries develop and use the questionnaire items many times. Adapted versions of the questionnaire have been used in many studies and the results from these studies also provided evidence on the validity of the measures. Several factors associated with HIV/AIDS such as demographics, risky injection and sexual practices were assessed. The questionnaire measured both knowledge and reported behaviour. Statistical data, observations and discussions with staff were used to cross-validate and supplement the data collected by the questionnaire.

Face validity regarding adaptations to the questionnaire (discussed in section 3.5.2.2, Procedures for the client survey) was maximized by having the Street Outreach staff, the Sexual Health Program supervisor, and the Medical Health Officer review the adapted questions.

Several constraints on validity were difficult to avoid in this study due to the nature of the population and the issues being studied. Selection bias was possible
because respondents were not randomly selected, but rather convenience sampling was used. The extent of self-selection bias was estimated by comparing the sample to the entire population of injection drug users with the Street Outreach service on the characteristics documented by staff: gender, age, ethnicity. Reasons for possible divergence of data are offered in Chapter 5, Discussion. However, this is somewhat limited by the lack of information available on the total population. Respondent recall bias was possible, but was minimized by repeating some of the same questions in slightly different ways within the questionnaire and by limiting recall to information to the past six months.

Another threat to validity is relying on data that is self-reported without a means of verification. This issue is problematic in all studies describing sexual and injection risk practices. Having trusted staff who were known to the clients as interviewers was thought to have made the clients more comfortable and possibly minimized problems associated with self-reported data.

As discussed in the section on Setting (3.2), client statistical records are kept according to client registration numbers. These records are not as accurate as they could be, largely due to the data collection tool. Observations allowed me to describe aspects of service delivery from the van by comparing what was being observed to some of the data gathered from the client surveys, client and clinical statistical records. By using a variety of sources, it was possible to strengthen each type of data collection tool and to minimize the weaknesses of any single approach. Patton states that "a multimethod triangulation to fieldwork increases both the validity and the reliability of evaluation
Having the staff provide feedback on the accuracy and analysis of the data from the observations strengthened the study. My background and level of comfort with the staff, subject matter, and population being studied increased reliability and validity even further.

3.7 Ethical Considerations

This proposal was submitted to the University of Saskatchewan Advisory Committee on Ethics in Behavioural Science Research as required (Appendix G). The Research and Development Committee of Public Health Services, Saskatoon District Health approved of the study, but did so informally.

Confidentiality of clients, privacy, and staff safety were considered as discussed in 3.5.2.2, Procedures for the client survey.

While pretesting the questionnaire, it became obvious to me that as interviewers, we would be privy to information about clients’ participation in unsafe injection and/or sexual practices which might be due to either lack of knowledge or misconceptions about HIV, hepatitis B and C. In discussion with the other interviewers, we decided that we would not feel comfortable unless we clarified information around potentially harmful practices. Following the interview, the interviewer clarified misconceptions or provided information to the client based on the need identified during the interview. Lack of knowledge usually centred around proper cleaning of needles and risks associated with hepatitis B and C such as sharing injection equipment, even with their partners.

At times it was difficult to remember all the things that needed to be clarified and
we had to prioritize the ones that posed the highest risk to the client and informally share the correct information with them. Initially we thought that doing so might be difficult if they were in a hurry to finish the interview and receive the $20.00, but we found that clients were more than willing to listen to the information.

3.8 Data Analysis

The client survey was the primary data collection tool for this evaluation. Closed-ended questions on the survey were coded and analyzed using the statistical package SPSS. Univariate analysis (e.g., frequency counts, percentages) was done to describe the responses to each item. In addition, key variables were analyzed by gender using categorical analysis (i.e., \( \chi^2 \)).

Responses to open-ended questions on the survey were reviewed for recurring themes, categorized and reported according to frequency of responses. After categorizing responses, a second coder confirmed the categories.

Data from observations and discussions with staff on service delivery were in the form of field notes, which described the program setting and physical environment of service delivery from the mobile van. Client-staff interactions were examined as suggested by Patton\(^\text{13}\) according to the patterns of interaction, frequency of interactions, and the direction of communication patterns (from staff to client or from client to staff). Because I drove the van during the observations, I was unable to observe the decision-making patterns between the two workers that are an important part of the program's social environment. Discussions with staff were included in the field notes. Once
analysis of the data from the observation field notes was completed, the program staff were asked to review the data and to comment on the accuracy and interpretation of the analysis.

Data from the client statistical records were analyzed using the EpiInfo statistical package because an EpiInfo database is used by PHS to collect these records. I reviewed the inventory and clinical statistical records as well as the policy and procedure documents, while the data from the management records were given to me by the department manager.

Results of the study will be shared with clients by way of a one-page summary of the satisfaction variables, and with program staff, management and other interested people by written report or oral presentation.
4. RESULTS

This study was conducted to describe aspects of Street Outreach service delivery, particularly from the mobile van; to describe the injection drug-using clients and their risks for blood-borne and sexually transmitted infections; and, to describe the clients’ perceptions of the Street Outreach service. The first section presents the findings from the observations and examines the resources used for the Street Outreach project, which pertains to the first research objective. Other sources of data for the first objective were program records, client statistical records and the pertinent client survey data. The second and third sections present the findings from the client survey which relate to the two remaining research objectives. The final section presents other findings of interest. The research objectives and sub-objectives as well as the corresponding process indicators are identified in each section.

4.1 Research Objective #1

To describe aspects of service delivery from the mobile van.

In order to describe aspects of service delivery from the van in a more simplified way, the findings in this section are reported according to the five service activities provided by Street Outreach. The corresponding process indicators are reported for each activity. Data were obtained from program documents, client and clinic statistical records, inventory records, and observations, as well as self-reported data from three
questions on the client survey.

The first section presents a general description of the mobile van from which services are offered, then a general description of service delivery and staff-client interactions obtained from observation, followed by a description of each of the five service activities as detailed above.

In March and April, 1998 I was able to observe service delivery involving needle exchange, condom distribution, provision of health/educational information, and client referral services from the mobile van. During the time that observations were being conducted, there was no opportunity to observe the Street Outreach nurse testing or immunizing anyone.

During the time I spent observing, it became even clearer to me that it would have been difficult to evaluate only the needle exchange activity of the risk reduction component because the other activities are so inextricably linked. Each activity overlaps with the others. With every needle exchange, condoms are offered and usually some type of health information is provided. Clients may be referred to other agencies and testing or immunizing may be provided. Needle exchange is not offered in isolation of the other activities, but rather the other activities are an integral part of the process of providing the service.
4.1.1 Service Delivery from the Mobile Van

4.1.1.1 Description of the Mobile Van

The Street Outreach staff reach the target population mostly by ‘going into the community’ and providing services to the target population of street-oriented youth, injection drug users and sex trade workers. They do so with the use of a ‘camperized’ mobile van which was purchased in 1993 with financial help from the Rotary Club. Four nights and one afternoon a week, staff stock the van with the hard resources (e.g., needles, condoms, bleach, alcohol swabs) needed to help clients practice safer sex and to inject safely.

The van is a beige 1984 Dodge that is beginning to show its age, with a number of little dents and scrapes. On the side of the van, written in brown lettering, is an acknowledgement to the Rotary Club for donating funds which helped to purchase the van. The overhead topper gives it a ‘camper-like’ appearance and allows enough head room for people to stand upright. Written on the front of the topper is the old Saskatoon Community Health Unit logo and the earlier name used by the program, ‘Safe Generation.’

Inside the van there are two seats, one for the driver and one for the passenger; all other seats have been removed. In the front of the van between the two seats, the engine housing provides a small space which has room for two coffee cups, pens or pencils, cards, or keys. A plastic holder has been added to store the client statistical sheets, contact book, or other notebooks. Neither of these spaces provide adequate room nor hold items securely. Things are easily spilled and scattered about the dimly lit van when
it is moving.

Above the seats in front of the van is a carpeted space which extends from one door to the other. This space is used to hold supplies, such as condoms or an open box of 1cc needles, which can be accessed quickly by the staff if clients are in a hurry and want only a few supplies. Directly behind the passenger seat are two smaller side doors which provide access for clients who come into the van to make their exchanges or just to chat. Curtains cover the windows on the side doors. Along this side of the van there is a cabinet which holds extra supplies such as containers and boxes of alcohol swabs. The latch which holds the door closed on the right-hand side is broken and needs to be fixed.

A table sits directly in the centre of the van at the back, with upholstered bench seats on either side. Staff use this space to sit and talk with clients, and the nurse uses it for testing and immunizing. It provided a more comfortable setting for us when we were interviewing clients. Overhead is a small space spanning the width of the van that looks like it may have been used as a sleeping space at one time. It now holds extra written materials. Although both overhead spaces provide extra storage areas, whatever is stored there is loose and gets scattered around when the van is moving.

Directly behind the driver's seat there is a narrow open space about two feet wide which the staff use to store containers that have been returned by the clients until they can be taken into the main office at the end of the shift. Large, white, round containers hold some of the smaller containers filled with dirty needles returned by clients. The staff keep a large container in this space for clients who bring a small number of loose needles back for disposal. Clients can put the needles directly into the container themselves.
There is sufficient room in this open space to hold extra containers if the staff stops by Hewgill's Pharmacy to pick up returns. A supply of plastic bags is kept easily accessible for the clients to carry their needles and containers.

There is a rack of written materials attached to the frame of the open space behind the driver's seat. Pamphlets on different health topics such as HIV are kept in the rack. Some of the materials look out-dated and do not appear to be used very often. The nurse generally has a supply of written material, for example, hepatitis C information. On the floor, the nurse keeps a large tackle box that holds the supplies she needs for testing and immunizing clients.

Behind the open space is a small fridge with two small cupboards used to store boxes of needles. Next to the fridge is a stove-top and sink with cupboards beneath them that provide additional storage spaces for clean needles.

The van has several side and back windows with curtains that can be drawn to provide privacy when the inside light is on or clients are in the van. Although the staff do most of the documenting with very little light, there is an interior light which can be turned on when gathering supplies for clients.

4.1.1.2 General Service Delivery

A typical night in the van (if there is such a thing) begins with the staff gathering supplies from the main office that they think they will need for the night. The cabinet and other storage areas are replenished nightly so there are always sufficient supplies on hand. Resources such as bleach, alcohol swabs, containers and other items such as the
cellular phone and client contact book are taken to the van. Once in the van, the resources are reviewed so that the staff do not have to come back unnecessarily. Boxes of 1 cc needles are the most popular and a check is made to ensure that several boxes are available. Before leaving, the staff person checks the messages on the cellular phone left by clients who have called earlier to arrange for exchanges. Telephone numbers or addresses are recorded in a notebook which the staff use as a running list of who needs to be contacted during the shift. If a client has left a number, a return call is made to arrange for service. These calls are generally handled first. The calls are usually prioritized in the order they come in, but sometimes vicinity dictates who gets service first.

If there are no calls pending or exchanges that need to be made at the beginning of the shift, the Street Outreach staff proceed to the areas where they know people hang out, for example, down 20th and 21st Street West. In Saskatoon, 21st Street West around St. Paul’s Hospital is known as ‘the stroll.’ On most nights, sex trade workers walk up and down waiting for ‘johns’ to stop. Other popular routes for the van to travel are along 19th and 20th Streets, around Victoria Park and down along Spadina Crescent. The Spadina area is usually frequented by the male sex trade workers.

Clients usually wave to the staff if they want them to stop, otherwise the van drives by. The staff explained that sometimes clients do not want the van to stop because they are negotiating with ‘johns’ or other people and do not want to be interrupted. The staff try to take their cues from the clients in this regard. Because I was driving the van, I was nervous at first about stopping when I should not have stopped or worse, not
stopping when a client was waving for me to stop. While this may seem simple enough, in daylight it most likely is not a problem, but for the most part, service delivery from the mobile van is done at night and with as little light as possible so as not to attract attention to the transactions or the people. It takes time to get used to working in the dark and I am not sure that I spent enough time to get used to it. With loose supplies sliding around and things constantly falling from the engine housing ledge as we drove, we were always looking for lost pens or other articles and I could not help but wonder about the safety issues in providing service in this way.

Sometimes the Street Outreach staff park the van. Popular spots for them to park are a doughnut shop on the corner of 22nd Street and Avenue P or in a grocery store parking lot on 20th Street West. When they are parked, they may be approached by clients who need condoms or needles or who want to chat, or get out of the cold for awhile. Other times, clients wave down the van and may ask the staff for a ride. If the van is going in the same direction or if the client is well-known to the staff, they may do so although they are not supposed to give rides. Clients are usually very appreciative on a cold winter night if they are able to catch a ride for even a few blocks.

4.1.1.3 Client-Staff Interactions

Regardless of the reason for the contact between the client and the staff, the staff respond in the same friendly and respectful way to everyone. As people approach the van, they are greeted. If they are known by the staff, they are referred to by name or if they have forgotten the client’s name they apologize and ask what it is. If staff know the
clients, they usually begin the interaction by asking them how they are or what's new. If the clients are not known to the staff, they are still greeted in the same friendly manner. If they do not know the clients well or not at all, they usually ask "What's happening?" or "What can I do for you?". This type of greeting invites the clients to approach and lets them know that they are there to be of help or to provide service. When clients leave after making an exchange or getting condoms, staff usually wish them well. Commonly used farewells are, "Take care" and "Have a good night." This farewell message provides a sense of closure after each contact.

 Clients usually dictate the amount of interaction between themselves and the staff. In the following example, the staff person only asked the client what she needed to know in order to make the exchange. The interaction was shorter and the staff person did most of the talking.

 In the area of Avenue South, a young Aboriginal woman dressed in a white parka waved us down. I pulled over to the curb and she ran up to the van. As she approached, the Street Outreach staff person rolled down the window, greeted her with a smile, and asked, "What can I get for you?". The young woman's only reply was, "Needles." The worker asked how many she needed to which the young woman replied, "50" as she handed the worker a white plastic bag with a container holding about 50 dirty needles. The worker asked if it was 1 cc's she needed and gave her an opened box of about 50-1cc needles. The young woman just nodded and was asked if she needed any alcohol swabs or condoms. She refused these supplies and started to leave. The worker said, "Nice to see you again." The young woman turned slightly, nodded and left.

 In a discussion with the staff person following this particular exchange, the worker said she did not know this client very well, however she had seen her once or twice before. She explained that sometimes it takes a long time before clients will feel comfortable
enough with the staff to chat. Some clients are just not big talkers.

There are times when the interaction between the Street Outreach workers and the clients is cut short because the clients are ‘sick’ (in bad need of a fix).

About 11:00 p.m. on a Tuesday night in April, a young Aboriginal woman in her early 20's waved us down. When the van stopped, she came up to the side door and waited for it to be opened. She was shaking and shivering as she leaned into the doorway asking for some clean rigs. She would not get in the van, but rather stood outside shifting her weight from one foot to another, puffing on a cigarette while she waited. She appeared in a hurry. The worker put a box of needles and some alcohol swabs in a plastic bag and handed it to the client. The client just grabbed the bag and left quickly. In her condition, there was no time for small talk—she was hurting badly and needed a fix.

At other times, the staff may need to curtail their conversations with clients because the phone rings or other clients approach the vehicle to make exchanges or to get condoms. On busy nights the phone can ring three or four times while an exchange is being made and the staff have to rush off, particularly if the client calling is in desperate need of clean needles.

An important aspect of client-staff interaction is the trust which allows the clients to share aspects of their personal lives with the staff as my field notes recorded:

A regular client well-known to the staff called asking to meet us on the corner of 19th and Avenue C. An attractive Aboriginal woman about 25 years old with short dark hair wearing jeans and a brown leather jacket, ran up to the van when we parked. She came to the side door and jumped in as soon as the door was opened. The outreach worker introduced me right away as the person doing the evaluation. This seemed to please her as she responded, “Cool.” She asked if she could have a clean rig and an alcohol swab, but refused the offer of condoms. The outreach worker seemed to know what size rig to give her and she put it in her pocket. Then she asked if we were going anywhere near the west end of the
city. She was on her way to her sister's and was wondering if we would give her a ride. We agreed to give her a ride part way because we were headed in that direction.

On the way, the young woman began talking about her kids and how she went to a particular store to get them some things before she spent the money on drugs. She seemed really pleased that she had done so. The outreach worker listened and commended her for doing so as well. The woman went on talking about her 4 year old daughter who could write. Her pride was obvious as she explained that when there is not much on TV, she writes certain letters on a piece of paper and her daughter copies them. Then she laughed and commented that her daughter is really turning into a couch potato because she doesn't want to go outside to play. During this time, the outreach worker just smiled and listened.

By this time I had completed some of the interviews and had listened to the stories that clients told me about their lives as injection drug users. I was surprised by just how ordinary the above conversation sounded from one who would probably call her life anything but ordinary.

Another quality deemed important by clients from survey data, was the staff's non-judgmental attitude towards them as injection drug users. Frequently clients commented that the staff did not ask a lot of questions, 'preach' to them or 'look down' on them because of their lifestyles. The following example illustrates the non-judgmental attitude of staff towards a well-known client who is an injection drug user.

On another night in March, a client called on the cellular phone saying she was in trouble. She was stranded at a restaurant downtown and needed a ride home. Ordinarily she would walk, but tonight she said she was afraid to do so because some girls had threatened to beat her up and she had already had one scuffle with them. We drove to the restaurant and picked up an obese Caucasian in her late teens or early 20's. I had met this young lady previously. She settled right in and began talking about everything from her experience in the restaurant and getting beaten up earlier to the birthday party she was going to go to for her niece. As we drove, she talked. The staff person just listened. No response was required. The client jumped from topic to
topic without waiting for any comment. When we dropped her off at the corner where she lived in an extremely dilapidated apartment building, the outreach worker cautioned her to be careful. With assurances that she would, she thanked us and left.

In discussion with the outreach worker following this incident, we wondered whether the client had really been in trouble or if she just wanted a ride. The outreach worker told me that they recognize that many of their clients are manipulators, mostly because of their drug use, and will try to take advantage of others at times. The staff set boundaries and have to be firm so that this does not happen. They rely on their experience and familiarity with the target group when having to make decisions in these situations.

In the example just described, the outreach worker knew that this young woman had been beaten up recently and was concerned that she may be in trouble again. After picking up the client and taking her home, I wondered if she had called for a ride because she knew she could trust the Street Outreach staff and depended on their help.

Traditional services do not keep the same hours that this target group does and, because there is a lot of distrust of the police given their involvement with illegal drugs, clients may be hesitant about calling them. I believe the staff's track record for being caring, open, and non-judgmental with clients encourages trust that enables clients to share aspects of their personal lives, ranging from their injection drug use to their fears about apprehension of their children. Given the comments from the client survey and from my observations, the clients who know the staff seem to count on them, not only for needle exchange or condoms, but for help with other issues that occur in their lives.

Another important aspect of the client-staff relationships or interactions that I observed was the support the staff provided to clients. Two examples spring to mind, the
first with a person who was not a client and the second with a client who was known to
the staff, but not well.

In front of the Albany Hotel on 20th Street, we were approached by a young Aboriginal woman who appeared intoxicated. She swerved from side to side as she approached the van. She asked if we would give her a ride home and the outreach worker said we really couldn’t. The young woman started to cry, saying she needed to get home to her kids. We asked where she lived and given that it was a considerable distance away, we decided that we couldn’t let her walk in her condition. The outreach worker invited her into the van and she got in, sitting on the floor behind the passenger seat. She kept repeating that she was “intoxicated” and far from home and that she was a “good person.” She told us that she knew about the van, but she didn’t do drugs. Her concern was whether or not we would tell welfare about her. The outreach worker assured her that we would not.

As we drove across the city, the young woman talked about being lonely. She was in the PALS program which is a parenting program offered by the Saskatoon Tribal Council, but she had not heard from her worker for awhile. She said she just wanted someone to talk to. The outreach worker handed her a business card and asked her to call her on Monday. By this time we were at the woman’s house. She grabbed my hand, squeezed it and thanked me for the ride. The outreach worker helped her to the door, gave her a hug and reminded her to call on Monday to talk.

In discussion with the outreach worker later, she told me that in her experience, often
times people just need to know that there is someone around they can talk to. This young woman was apparently struggling to keep her family together and getting help from the PALS program, but for some reason had not been in contact with the worker assigned to her. It may be that even though there are organizations in place to help, connections are tenuous for whatever reason and clients do not use the services.

Around 9:00 p.m. on a Tuesday night in April, we took a call from a client not well-known to the staff. She and her partner are both injection drug users and she was pregnant at the time. She called to ask for some baby clothes and diapers for her toddler.
Luckily, we had some diapers and offered to drop them by her house. The outreach worker explained that they were aware of this woman’s drug use and her pregnant state and that they were trying to establish a closer relationship with her, to be of more help. Because she was not well known to them, the worker was pleased that she was reaching out and she hoped they would become more closely ‘connected’ to her. When we dropped off the diapers, the outreach worker told her there were places in Saskatoon where she would be able to get baby clothes. Because the worker was in the office the next day, she offered to help her try to find some.

4.1.2 Needle Exchange

4.1.2.1 Number of Needles Exchanged

According to the inventory records from 1997, 233,000 needles were ordered from January to December. The number of needles ordered in the first quarter of 1998 is more than 2,500 over that which was ordered during the same time last year, which suggests the total number of needles distributed by the program will be greater than the number distributed last year.

According to the client statistical records from 1997, the number of needles issued was consistently higher than the number of needles returned. The Street Outreach program issued a total of 199,456 clean needles from the three sites where exchanges are made. The number of needles distributed to clients is approximately 50,000 greater than the number distributed the year before. The number of needles issued ranged from 11,667 in June to 21,689 in August with an average number of 16,621 needles issued.
monthly by the program staff. Of the 199,456 needles issued, 181,579 (91%) were issued to specific clients whereas 17,877 (180 boxes, 9%) were issued to clients not specified by number or not registered with the program. Although there is always an inventory of clean needles in the office and the van, the number of needles issued and documented by staff appears to be underestimated when compared to the inventory records for 1997. Some of this discrepancy may be explained by the inconsistent way in which needle exchanges done at Hewgill’s Pharmacy were being entered in the database.

The number of dirty needles returned in 1997 was 146,175, which is considerably more than the 71,945 returned the year previously. In 1997, 7,801 (5%) needles were returned for disposal, but not specified by client number. In 1996 the percentage of needles returned to needles issued was 48%, whereas for 1997 that rate had increased to 73%. The rates of needles returned to needles issued ranged from as low as 57% in February to as high as 97% in August. Figure 4.1 illustrates needles exchanged in 1997 by the Street Outreach program.

The majority of exchanges occurred from the van and I suspect this to be accurate. Provision for this information is on the daily statistical record kept by the staff, however it is not always recorded and the way in which it was entered in the database for the year being examined was not satisfactory. For example, there were five different database fields for entries pertaining to exchanges occurring from the van. Although 117 needle exchanges were done at the STD clinic, there was no field for data entry pertaining to those exchanges in the 1997 data set and the information was not recorded on the client statistical records. This matter has been corrected for the 1998 dataset. Only
65% of all needles returned and 64% of all needles issued are documented by site in the
1997 data set.

Figure 4.1    Total number of needles exchanged by month in 1997

4.1.2.2 Policy and Procedures for Needle Exchange

While reviewing program records for background information on the program, I
reviewed a policy and procedure document for Street Outreach dated February 1993 and
revised at a later date not specified. Given the similarity between the two documents, I
suspect the time frame for the revised version was not long after the initial one. This
protocol briefly described the collection and distribution policies to be followed by staff
when doing needle exchange. At the time, containers were not being issued to clients for
the return of their dirty needles. Clients were expected to deposit their own dirty needles into the containers in the van. They were to count out the returned needles so that the staff would know how many were being returned without having to touch them. Other guidelines referred to following universal precautions when handling dirty needles and exchanging needles on a one-to-one basis.

The procedure to be followed for new clients included giving up to five clean needles without any dirty ones brought in for return the first time a request was made for needles. The policy read that if this practice continued (more than twice), the client should be referred to the nurse. The quota per client per visit was listed as two to twenty needles. Bleach kits and alcohol swabs were to be given with every needle exchange, and although new needles were to be emphasized for each injection, staff were to demonstrate proper cleaning of needles if clients admitted cleaning their needle. Each client requesting needle exchange was to be given a code number in order that exchanges might be tracked (this number system has since been changed). A risk profile card was to be completed when a client was registered and staff were to instruct the clients about the legal ramifications of carrying syringes. Clients were asked not to compromise the program by carrying out illegal activities within the vicinity of the van. The policy and procedure manual also provided guidelines for the proper storage of dirty needles when they are returned by clients.
4.1.2.3 Observations of Needle Exchange Service Delivery

a) Service Delivery

There does not appear to be a standardized procedure for doing needle exchange. The procedure depends on the situation, the client (e.g., how well the client is known to the staff or the staff to the client), the amount of time clients and staff have available, and the staff person, although the variability seems to depend least of all on the staff person. Most regular clients will call the staff and ask them to bring the supplies they need to their homes. Staff usually tell them how long it will take before they can get there and ask them to watch for the van. If they cannot make the delivery immediately, they ask for the client’s telephone number and they will call when the van pulls up to the client’s home. In some situations, and depending on the staff person, supplies may be taken right into the client’s home and containers with dirty needles are usually brought back to the van. Staff seem to be comfortable going into some clients’ homes, but these are usually well-known, regular clients. If the staff do not go into the home, the client comes out to the van where needles are given and dirty ones are returned.

b) Access to Service

Although limited as a data source, field notes from my observations indicated that the majority of services from the mobile van occurred later in the evening. They revealed that in the earlier part of the shift, staff prepared for the night by restocking the van, returning messages and arranging for service to clients. If there were no clients in need of service immediately, the staff drove to popular places as described earlier. Sometimes there were calls as soon as we began, but most of the services observed were
after 9:00 p.m. Data from the daily client statistical forms supported this observation. Because there is no field available, this information is not entered into the database. Staff do document the time services are delivered on the client statistical forms. A review of the 1997 client statistical forms suggested that 80% of contacts were made after 9:00 p.m. Table 4.1 illustrates the times clients access services from the mobile van. Data were reviewed for every second month from January to December 1997. Another measure of accessibility might be to document the response time for staff to deliver services after being requested, and the number of clients who do not receive service because the requests are too late to be handled during the hours the van is out. Street Outreach staff do not document this information now.

Table 4.1 Distribution of client contacts accessing van services by time for every second month from January to December 1997

<table>
<thead>
<tr>
<th>Time</th>
<th>% (N) client contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before 8:00 p.m.*</td>
<td>4 (79)</td>
</tr>
<tr>
<td>8:00 p.m. - 8:30 p.m.</td>
<td>6 (114)</td>
</tr>
<tr>
<td>8:31 p.m. - 9:00 p.m.</td>
<td>10 (182)</td>
</tr>
<tr>
<td>9:01 p.m. - 9:30 p.m.</td>
<td>23 (430)</td>
</tr>
<tr>
<td>9:31 p.m. - 10:00 p.m.</td>
<td>11 (205)</td>
</tr>
<tr>
<td>10:01 p.m. - 11:00 p.m.</td>
<td>23 (435)</td>
</tr>
<tr>
<td>11:01 p.m. and later</td>
<td>23 (436)</td>
</tr>
</tbody>
</table>

* Does not include Wednesday afternoons beginning in June.

c) Needles Being Returned by Clients

The dirty needles being returned from regular clients are usually in the containers
given them by the Street Outreach staff. There are two different sized containers, the largest one is a hazardous waste container which meets the standards for biohazard containers according to Saskatoon District Health’s policy; however, it is not safe because it breaks easily and the lid falls off. Each holds approximately 400 dirty needles. The smaller container holds about 50 dirty needles and is not puncture proof, but it is a suitable size for those who use fewer needles and have fewer returns.

Sometimes clients return dirty needles in plastic bags. These are put directly into one of the large white, round containers which are taken in to the Idylwyld office nightly so that dirty needles are not left in the van, in the event that someone breaks into the van. Staff do not handle dirty needles directly. They roughly estimate the number of dirty needles being returned and put them into the appropriate containers available in the van.

Needles are not always returned on a one-to-one basis. Clients are not refused access to clean needles because they have not returned their dirty ones. There are no limits on the number of needles given clients. One regular client uses six boxes of needles (600 needles) per week and this particular client returns all of her dirty needles.

When the staff exchanged needles, the message emphasized repeatedly was the need to safely dispose of dirty needles and not to leave them lying around on the streets. Because of the number of calls recently about dirty needles found scattered in the streets or around certain apartment buildings, the staff commented that they have made an effort to talk about proper disposal even to clients who are regulars and return their dirty needles quite faithfully. For example, one of the outreach workers, when exchanging needles for a regular customer, commented, “I know I don’t have to remind you not to
throw them around on the street.” The young woman just laughed and said, “No, you sure don’t.”

d) **Needle Exchange with New Clients**

As explained earlier, clients who are registered with the program are assigned four-digit numbers. The first two digits indicate the first letter of their first name (e.g., if the name begins with the letter ‘a’, the first two digits of the client number would be 01) and the last two digits indicate the latest number assigned (e.g., if the last client number beginning with 01 and ending with 08 was given to someone, the next number would be 0109). During the interviews, it was very obvious that for the most part, clients do not know their numbers and as a result they are not used except by the staff. The exception to this are the exchanges done at Hewgill’s Pharmacy where clients are encouraged more often to use their numbers.

According to the policy and procedure manual dated February 1993, only clients accessing needle exchange are to have numbers and there are no guidelines as to the number of time people can get needles before being registered. According to the program staff, there are clients who have registration numbers who do not access needle exchange. This group is likely to increase with the number of clients on the methadone program.

The following examples illustrate needle exchange with two different new clients.

A young Aboriginal male approached the van when we were parked at the corner of 22nd Street and Avenue P. As he approached the vehicle, he called out, “Hey.” When I said “Hi,” he immediately asked if he could get some rigs. I asked him to come around to the side door. The outreach worker opened the side door and invited him in. He did not get in, but rather stood outside leaning in and repeated his request, this time asking for a box of needles. The outreach worker introduced herself and asked him what type he needed. She asked if
he had ever got needles from us before and he commented that he hadn’t. As she got the supplies ready for him, she told him about the program, how client were issued numbers, where they could get clean needles, and how to dispose of dirty needles properly in the containers. She handed him a card with the cellular phone number and explained how he could call to arrange for exchanges. She also explained the importance of not sharing needles or injection equipment.

The outreach worker took the client contact book from the front of the van and asked the young man for a name and a birth date. The fellow asked if he could use a false name, but before the worker could comment he gave her his name and his birth date. He thanked her and left.

In discussion with the Street Outreach workers, it seems that there is no standardized procedure for registering clients with the program. That is, sometimes clients will be registered the first time they access needles and at other times, not until they have exchanged needles once or twice. In this case, the outreach worker commented that she registered him and asked for some demographic information because he had asked for a box of needles rather than just a few. She added that sometimes they do not get as much information as she did this time when it is someone asking for needles for the first time. If there was any hesitation on his part, she would not have asked for the information or assigned him a number at that particular time. After the staff get to know the clients, they can gather more pertinent information about them. Unfortunately, the staff may have the information, but it is not documented anywhere. The risk profile for each client is not completed on the daily client statistical form.

In the above example, the outreach worker did not give the client a card with his registration number on it, which is the usual procedure.

In another example, a new client was signed up in the parking lot behind her apartment block in the early evening. The client had spoken with the outreach worker about getting new needles,
but had sent her daughter out to get them. The daughter was about 20 years old. The outreach worker sat and explained to the daughter how the program worked, how exchanges were done, where they could be done and how to contact the workers. She also talked about safe injection practices (e.g., not sharing needles or other equipment) and safe disposal of dirty rigs. A pamphlet of services, a card with her registration number, and the phone numbers to call for service were given to the person to give to her mother. When the worker handed the white plastic bag with the supplies to the client’s daughter, she asked if she minded telling her which drugs her mother injected. Without the slightest hesitation, the daughter told her and left.

In discussion with the staff person about the exchange in the example above, she explained that this particular client had been given needles from the van a few times previously, although she had always sent her daughter out to the van to get them. The client was new to Saskatoon and had been referred to the program by her friends. In this case, the outreach worker thought it would take time before the mother actually came herself. The most important thing was that she got the information and clean needles.

Given that needle exchange implies illegal activity, mutual trust takes time to develop.

\textit{e) Distribution of bleach}

Bleach kits are no longer distributed to needle exchange clients. The staff carry one-litre containers of bleach which some clients still request. The staff explained that some clients like to put bleach in the containers used to dispose of their dirty needles. Staff encourage clients to use a new needle each time they inject rather than cleaning the needle, but they suggest using full-strength bleach if clients do choose to clean their needles. During the time I observed, I did not hear the staff explain the recommended way to clean needles before re-using them.

Alcohol swabs and condoms are offered to clients accessing needle exchange.
The majority of clients took the alcohol swabs and some took condoms as well.

j) Documentation

After each contact with clients, some staff record the data being collected directly on the daily client statistical form (Appendix F) and others document in a notebook for transcribing to the statistical forms later. Staff record the time and place of the contact, client demographics including age, gender, ethnic background, if the client is new, type of contact, basic risk (sex trade worker or injection drug user), type of service and prevention strategies (condoms, needles, referral) discussed during the interaction. The number of needles issued as well as the number of needles returned is recorded, along with any other data such as the number of condoms given, where referrals were made, type of health information or counselling and the client number. As discussed earlier, some of the information is not recorded and there is confusion among staff about what some of the categories mean.

4.1.3 Condom Distribution

4.1.3.1 Number of Condoms Distributed

The number of condoms used by Street Outreach is not documented or accounted for other than on the daily client statistical sheets. Healthy Lifestyles Department has a budget for condoms, but this is not separated from the Sexual Health program budget. That is, the cost is calculated for the entire program area, but not for the Street Outreach project alone. The exception to this are the Ramses brand condoms purchased from Julius Schmidt because they are only used by Street Outreach. Some of the long-time
Street Outreach clients prefer Ramses condoms and ask for them specifically. Although attempts have been made to get these clients to switch to the cheaper Hardcover brand used by the Sexual Health program, some clients have not been convinced to change and continue using the Ramses brand.

According to the 1997 inventory records, from January to December, 260 gross (144 condoms per gross) of lubricated and 180 gross of non-lubricated Ramses condoms were ordered from Julius Schmidt to be used for the program.

According to the 1997 client statistical data, a total of 231.4 gross or 33,317 condoms (29,961 lubricated and 3,356 nonlubricated) were distributed to clients in 1997. According to inventory records kept by the nurse ordering supplies for Sexual Health for the period from January to December, 1997 a total of 118 gross Hardcover (lubricated and non-lubricated) and 161 gross of Ramses condoms were documented as being taken by the Street Outreach staff for distribution. These numbers represent approximately 48% of all condoms used in the Sexual Health program area for that period of time. For the first quarter of 1998, 8 gross of Hardcover and 34 gross of Ramses had been marked as taken by Street Outreach staff for distribution to clients. The staff commented that they did not always remember to mark down the number of condoms they were taking on the inventory record kept at main office. Since condoms are recorded on the daily client statistical form in the dimly lit van, I would suspect that the inventory records are more accurate. However, both records probably underestimate the actual number of condoms distributed by Street Outreach. The cost of condoms used by Street Outreach could be calculated using the information from the inventory records kept by the nurse ordering
supplies for Sexual Health.

4.1.3.2 Observations of Condom Distribution

As I mentioned earlier, whether clients were asking for needles or condoms, the staff greeted them in the same way. Although similar in this regard, there were some differences noted when condoms were distributed without needles. For example, the length of time spent with clients was shorter, clients often seemed younger, they approached the van in groups, and they did not call on the cellular phone to arrange for delivery. This type of service delivery by itself seems far more spontaneous and less structured than needle exchange.

Clients requesting condoms usually did not get into the van unless they knew the staff and did so just to chat or to get in from the cold. Staff asked the clients what kind of condoms they would like. Both lubricated and non-lubricated condoms are distributed and their choice depends on the whether they use them for sexual intercourse or oral sex, or personal preference. Some injection drug users use non-lubricated condoms as ‘ties’ (tourniquets) to pump up their veins for injection purposes. The staff may give a few condoms to a strip of condoms (12), depending on the client. Although it takes a few minutes for staff to find a specific flavour requested by some clients, generally the time taken to distribute condoms was less than the time it took to provide needle exchange.

During the time I observed, the van was often approached by groups of young boys and girls asking for condoms. When we were driving by a doughnut store on 20th Street one evening, six young girls waved for us to stop. I pulled into the parking lot and
they ran up to the van, giggling. The outreach worker said, “Hey, what can we do for you?” They asked, almost in unison, if they could get some condoms. The outreach worker asked them what flavour of condoms they wanted. They all giggled and asked what flavours we had. The most popular colours were black (‘licorice’ flavour) and purple (‘grape’), although some chose red (‘raspberry passion’). While this was happening and we were tearing apart the condoms so that they each got a selection of colours and flavours they wanted, I felt much the same as I do handing out treats to the kids at Hallowe’en. If you have more than one kind of treat, sometimes the kids will ask for one of each, giggling while doing so.

After making a stop at Hewgill’s Pharmacy on 20th Street, picking up containers of dirty needles and dropping off a supply of clean needles for them to distribute, a large group of 8 to 10 young boys, barely in their teens, approached the van. They were extremely noisy, asking loudly if they might have some condoms. They were given one or two each, but that did not satisfy some of the more persistent ones. About three of them stood at the van asking for a red condom, then a green condom, and on and on. I was losing patience with them and thought how I just wanted to drive away. The outreach worker was far more pleasant and patient than I was, and they finally left. As they were leaving, she told them firmly, but still in a polite manner, not to drop the condoms on the street. I suspected that they were going to use them for water balloons.

Although often Street Outreach clients ‘working the streets’ are injection drug users as well, there are clients who work the streets but are not injection drug users and still require condoms. One evening in March, we were going west on 20th Street, when
an attractive woman waved for us to stop. She was quite striking with long, dark, curly hair and purple lipstick. She wore dark pants and a black and white short jacket. When the outreach worker rolled down the window and greeted her, the woman asked in a low whispery voice for condoms. The worker asked if she wanted ‘lubed’ or ‘non-lubed’ condoms. She asked for flavoured ones, which are lubricated, and when she got them, thanked us and continued walking down the street.

Usually, after someone had stopped us, I asked the staff if they knew who the people were. As we drove away this time, the outreach worker told me that she knew that particular person quite well. In fact, ‘she’ was a man who dressed like a woman and worked the streets. The staff person commented that they were always concerned about the males who cross-dress and work the streets because they are very vulnerable and often victims of violence.

Sometimes more than one group of people approached the van as it sat on the side of the street. Usually those waiting will stand back until the people being helped have finished their business with the van. At other times, if they happen to know one another, they will talk among themselves while they’re waiting. One night while we were stopped on 22nd Street giving out condoms to two young women, a couple approached and stood at a distance until the women walked away from the van. The couple advanced to the window, asking what kind of condoms we had that night. The outreach worker told them and asked how many they needed. The couple took only a strip of twelve flavoured condoms, thanked us and kept on walking down the street, hand in hand. They were not regular clients, but obviously knew they could get condoms from us.
4.1.4 Provision of Health/Educational Information

4.1.4.1 Types of Health Information Given to Clients

According to the daily client statistical records for 1997, printed material was given to clients a total of 314 times. There is no documentation to indicate what kinds of printed material was given clients. Although specific types of health information are not documented as such, the staff do document the types of counselling they provide clients. Counselling may or may not include provision of health information. For example, when the staff talk to clients about risk reduction it is defined in the guidelines for documenting statistical information as ‘any provision of information or education re: risks and recommended behaviour change.’ Risk reduction could include providing information about the safe disposal of needles, condom use, not sharing needles or equipment, hepatitis B immunization, or HIV testing. Other topic areas available as fields in the database are: abuse, chemical dependency, coping with HIV, life skills, mental health, pregnancy, sexuality, and ‘other.’ The staff indicated that they often counselled clients regarding suicide, grief, or family issues. In examining the client statistical database for the purpose of this evaluation and in discussion with the staff, it became clear that even with definers, these topic areas were too broad, open to interpretation by individual staff members, and not adequate to reflect the topics discussed with clients. This likely explains why the ‘other’ field is selected almost as often as ‘risk reduction’ on the statistical form. For these reasons, this information was not used as data for this evaluation.
4.1.4.2 Observations of Providing Health/Educational Information

The only standardized messages I observed clients being given involved disposing of needles properly to keep dirty needles off the streets. Sometimes the staff talked about sharing needles and sharing equipment. This message seemed to come up more often when the clients were not as well known to the staff. New clients were cautioned about sharing needles and other injection equipment as well because of the risks of HIV and hepatitis B and C. In my discussions with staff, they all agreed that for the most part, health information given clients is dependent upon client need as identified by staff or at the client’s request for information. Information is usually offered face-to-face, but sometimes written material is used to supplement or reinforce verbal information. The Street Outreach nurse usually has a supply of written material on hepatitis C, for example, because with screening provided as a service and a lot of injection drug users discovering that they are testing positive for hepatitis C, the need for this type of information is paramount. If clients request other types of information, the outreach staff will find appropriate material and copy it for them. For example, sometimes clients request information on methadone. The staff will put together a package of information they think would be helpful and arrange to go over the information with the clients as arranged.

During the time I was observing, clients requested information about a variety of subjects including: birth control pills, Depo-Provera (injectable birth control), pregnancy, prenatal classes, pregnancy tests, treatment of abscesses, hepatitis B and C, HIV, using alcohol swabs when injecting, and general health concerns such as the flu or infections.
Staff provided information on topics such as hepatitis B and C and HIV transmission when clients were new or they suspected insufficient knowledge in those areas. The information offered was usually provided very informally, face-to-face, and on a 'need to know' basis. They seemed to know how much information was enough without imparting too much or going beyond the person's ability to understand.

The following examples from my field notes illustrate when information was sought by clients and when information was given, based on the staff's recognition of a knowledge deficit in a particular area.

One evening in March, we stopped to have coffee at the doughnut store on the corner of Avenue P and 22nd Street. At a table in the corner, a group of people were having coffee. One of the men was a long-time client of the program. As we were getting our coffee, he called for us to join them and we did. One of the women introduced herself and asked us what we did. The outreach worker explained who we were, talked a little about the program and the services that we offered. The woman immediately identified herself as being hepatitis C-positive and explained she was looking for someone who would be able to give her more information about hepatitis C. She had been diagnosed while incarcerated and got little information from the medical staff in prison. She was well aware of the publicity surrounding hepatitis C because of the federal compensation packages being offered victims who had been infected since 1986.

The outreach worker asked if there were any specific concerns she had at the moment or if she would like to arrange another time to talk about hepatitis C and any other health concerns she had. The woman was quite willing to arrange another time. The outreach worker was open, attentive, and acknowledged her concern about not getting adequate information and assured her that she could help with information about hepatitis C. She did not probe or ask how the woman got infected. She very briefly described how hepatitis C was transmitted, which I thought was the most important information the woman needed to know at the time. Although general information, more detailed information could be discussed privately when they met again.

In April, a new client who was an injection drug user had just been
diagnosed with hepatitis C by her family doctor. She was overwhelmed by the diagnosis and kept shaking her head and commenting how she found it hard to believe. The worker began by listening to the client talk about her experiences that led up to finding out about being hepatitis C-positive. As the client spoke, she would think of questions and looked to the worker for answers. The worker answered as many questions as she could and if there was something she was unsure of, she offered to find out. After all the questions were answered, the worker reviewed the necessary information and reiterated about the effects of drinking alcohol on hepatitis, disposing of rigs properly, being careful with razors, toothbrushes and nail clippers and the rationale for doing so. She listened to the woman’s concerns and commended her for taking responsibility for her own health now that she was aware of her diagnosis. She suggested follow-up with her family doctor and the specialist she had been referred to. Then she reviewed the services available to her and her children (e.g., immunization against hepatitis B) and offered to meet again.

Another example arose from a situation where we were called to an address to make an exchange.

A young woman in her early 30's came out of her apartment building just as we pulled up across the street. She was fairly tall, extremely thin, with blonde hair and a pale complexion. As she walked around the van, I wondered if she was sick (in need of a fix). The outreach worker opened the sliding door for her, greeted her and invited her into the van. Although she didn’t step into the van, she leaned into it and handed the outreach worker a container of dirty rigs and asked for two boxes of new 1 cc needles. The outreach worker asked how she was and she started talking about not being well. She explained to us that she was unable to eat and “shit the bed at night,” and asked us what we thought it was. The first thing we did was ascertain whether or not she had been in touch with her doctor and then explained the importance of drinking fluids to replace what she lost through diarrhea. I asked some general questions about other symptoms and encouraged her to call her doctor again if things did not improve within a day or two. I realized at that point that the side effects of the drugs or addictions could mask many health problems and yet, so often, for these reasons, drug users do not feel comfortable accessing traditional medical services.

In my discussion with the staff about providing health information and general health care and follow-up with this target group, I realized that they are in a position to reach
these people in terms of prevention and early on in the disease process and may be able to provide a broader scope of services related to this.

Another example from observations regarding the provision of health information arose when the staff person recognized lack of knowledge related to hepatitis.

The staff person was getting supplies for a new client and while doing so, asked if he knew how to protect himself from HIV and hepatitis B and C. The young client looked really puzzled, shook his head and commented that he didn’t know what hepatitis was. The outreach worker explained they were all viruses that could be transmitted by sharing needles or injection equipment and by unprotected sexual intercourse. At that point the young man commented, “I’m not stupid, I know what that is.”

I am not sure what precipitated the outburst, unless he knew about not sharing needles but did not know that it could cause hepatitis. Given his body language, especially the puzzled look on his face when asked about HIV and hepatitis, I would have given the same information and I cannot explain this reaction to information.

The incident just described reminded me of the reactions I got from a few of the survey participants when I asked them to explain how they cleaned their needles. They told me that they knew how to clean them “properly.” Their reaction to this particular question made me feel as though I would be insulting them if I asked them to be more specific. When I did not get the same response to other questions involving transmission of HIV or hepatitis, I thought it could not have been that they felt threatened by their lack of knowledge. I have no explanation for this other than being isolated incidents.

If the clients need more information than the outreach workers can give or if the clients ask about testing or immunizing, they are referred to the nurse.
At one time, a young woman called the cellular number requesting information about hepatitis B immunization. The outreach worker collected some written material and took it over to the woman’s apartment. When giving her the material, she was also given broad, preliminary information about transmission of both hepatitis B and C. In addition, she was given the Street Outreach nurse’s card and was told that the worker would communicate with the nurse to arrange for follow-up and immunization. The outreach worker indicated that she would leave a message on the nurse’s voice mail with the information she would need to follow-up with this client.

In another situation after we had taken a supply of clean needles to a regular client’s house and picked up a container filled of dirty ones, she asked about getting tested for both hepatitis and HIV. She explained that her sexual partner had been with another partner who was HIV-positive and she was very concerned about her health and wanted to be tested for “everything.” The client said she knew about HIV, but did not know much about hepatitis. The outreach worker told her briefly that hepatitis was a virus and that there were different kinds, and explained how a person could become infected. Then she suggested that the client call the nurse to make arrangements for testing.

Because this was a regular client that the staff saw every week, the outreach worker was confident that the client would call the nurse herself.

4.1.5 Client Referrals

4.1.5.1 Number of Client Referrals and Where Client Referrals are Being Made

According to the client statistical records from 1997, Street Outreach staff made over 500 client referrals. Each time the staff talk to a client about an agency, organization or other people who may be of help, it is documented as a referral. The data form has eight referral sites plus an ‘other’ field which can be selected for data entry purposes. Table 4.2 illustrates the types of client referrals made from the van which the
staff have documented during the past year.

Table 4.2 Frequency of documented client referrals according to where referrals were made during 1997

<table>
<thead>
<tr>
<th>Name of Referral Agency/Individual/Organization</th>
<th>Number of times clients referred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical or dental clinic</td>
<td>59</td>
</tr>
<tr>
<td>STD clinic</td>
<td>54</td>
</tr>
<tr>
<td>Saskatchewan Alcohol &amp; Drug Addiction Commission (SADAC), Native Addictions Council</td>
<td>39</td>
</tr>
<tr>
<td>Social Services</td>
<td>13</td>
</tr>
<tr>
<td>District Public Health Nurse</td>
<td>12</td>
</tr>
<tr>
<td>Training/Employment</td>
<td>7</td>
</tr>
<tr>
<td>Mobile Crisis</td>
<td>4</td>
</tr>
<tr>
<td>Healthy Mother Healthy Baby</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>318</td>
</tr>
</tbody>
</table>

Note: Clients may have been referred more than once and to more than one agency.

As noted in Table 4.2, the ‘other’ column is used most often. In discussion with the staff, they indicated that referrals are often made to places such as Egadz (a downtown youth centre) or the Sexual Assault Centre. The referral sites reflect both specific agencies (Healthy Mother Healthy Baby, Mobile Crisis) as well as general categories (training/employment) according to the client statistical form.

The instructions for documenting information on the client statistical information sheets suggests staff count referrals each time an agency, organization or resource person is discussed with a client. In the policies and procedures for the program, the guidelines for referrals suggest that the staff continue to refer program users to the appropriate
agencies and that referral follow-up should be carried out to track whether the individual was able to access the service required.

Follow-up of client referrals is not consistent and depends on the situation, the referral, and the client. If the referral requires staff to help the clients access other services and is more formal, it is more likely to occur. However, because clients are not always reliable nor easy to locate, it is sometimes difficult to provide follow-up to this group. More informal referrals, such as referring the client and then asking if he/she acted on the referral, are difficult to assess because they may not be remembered by the clients or the staff.

4.1.5.2 Observations of Client Referrals

Client referrals appear to be quite spontaneous and, just as in the provision of health information, of two types: those based on the worker’s assessment of the client’s need and the workers’ awareness of appropriate agencies or people who might be of help to the clients as well as those requested by clients themselves.

A young Aboriginal woman called the cellular phone and asked us to stop by her apartment. She was known to the outreach worker and at one time had been an injection drug user as well as a sex trade worker. When we got to her apartment, she invited us in, but we stood in the hallway talking. She explained that her sister was coming to Saskatoon from Regina and she feared that the sister was going to get their niece to start ‘working’ the streets. She did not know who she could talk to about her fears. She told us that her sister had sold her own daughter to a drug dealer in Edmonton because she owed him money for drugs and she was convinced that the sister would have no qualms about putting her niece on the streets, too. The outreach worker said she was unsure who would be the appropriate agency to help in this situation. The client kept on repeating that she just could not allow this to happen again. She was not on speaking terms with the sister and had not been for years, but did not
think that she could stop it from happening by herself. The outreach worker suggested that she might be able to get some assistance from the police. She looked through her business cards and found two names of police with the morality division and gave the client the names and numbers to call for advice on how to handle the matter.

When the outreach worker was talking to the woman in the doughnut shop about hepatitis C, it quickly became clear that this young woman had issues other than being hepatitis C-positive. She told us about having spent many years in prison and having “a lot of garbage from her past” to deal with. The outreach worker asked how she would feel about a support group, but the woman said she did not want to talk to others like herself. The outreach worker asked if she had heard of Elizabeth Fry (a group that works with women who have been incarcerated) and another group called PEERS (a support group for former prostitutes) and when she indicated that she had not, the outreach worker explained what the programs were and the type of help they offered.

In discussion with the outreach worker, she indicated that when they tell clients about other agencies, they will do so verbally but that it is helpful if they have brochures to give the clients as well.

4.1.6 Provision of Testing/Immunizing

4.1.6.1 Number of Clients Tested

Since needle exchange began in 1993, clients have had the opportunity to be tested when the nurse is in the van or to make arrangements for her to provide testing at their homes or at the main Idylwyld office. Statistical records are kept by the Sexual Health program for all clients tested, regardless of whether they are tested at the STD clinic, in Corrections, or at the van. As explained earlier, data are recorded according to the name used by the client, date of birth, testing done and results of those tests. Blood screening for syphilis, hepatitis B antigen and antibodies, and hepatitis C antibodies are
usually offered to clients attending clinic or being tested from the van.

\[a\) \textit{Screening for Hepatitis B and C}\]

There is a minor discrepancy between the statistics kept by the Street Outreach nurse and those kept in the clinic statistical records. For the purpose of this evaluation, the data from the clinic statistical records will be used. In 1997, according to clinic statistical records, 53 Street Outreach clients were screened for hepatitis B and 54 for hepatitis C. For the first quarter of 1998, 14 clients have already been screened for both hepatitis B and C. Although the nurse for the program is available for screening and suggests that clients get tested routinely, it is voluntary and done only at their request.

Sixty-eight per cent of clients from the client survey reported being tested for hepatitis B and C. Five clients reported being tested for hepatitis C only, while 4 reported being unsure of what they were tested for. Thirty-five clients (35/89) reported being tested for hepatitis B or C from the van.

\[b\) \textit{Testing for HIV}\]

HIV testing is anonymous and includes pre-test counselling. Counselling includes assessment of client risk, providing the client with information about the transmission of HIV and explaining potential test results. Clients must get their results in person at which time post-test counselling is provided by the nurse. At this counselling session, if the result is negative, prevention of HIV is reviewed in relation to the client’s risks. If, however, the result is positive, more in-depth counselling about living with HIV is provided.
The number of HIV tests done by the Street Outreach nurse has increased each year. A total of 29 HIV tests were done up to and including 1995, with 59 more tests done in 1996. In 1997, a total of 68 HIV tests were done by Street Outreach out of a total of 670 anonymous HIV tests done by Public Health Services. For the first quarter of 1998, 18 HIV tests had been done by the Street Outreach nurse. Until the end of the first quarter in 1998, a total of 174 HIV tests for Street Outreach clients had been done since anonymous HIV testing began in the fall of 1993.

From the client survey, 37 clients reported that they had been tested for HIV from the van, while 86 in total reported having been tested for HIV at some time. Fifty clients indicated that they had been tested for HIV anywhere from one week to nine months ago, while 36 had been tested from one to six years ago. Sixty-four per cent reported being tested within the past year.

4.1.6.2 Number of Clients Immunized Against Hepatitis B

The number of clients being immunized against hepatitis B has increased each year. During 1996, 22 clients received their first dose of vaccine, while 8 received their second dose. By 1997, those numbers increased to 39 and 26, respectively, and by May 1998, 15 clients had received their first dose of vaccine and as many as 13, their second dose. These figures are kept by the Disease Control Department of Public Health Services for the provincial health department. However, as explained earlier, there are no records kept for clients who have received all three doses of vaccine, the usual dosage for immunity. In order to extract that information, the Street Outreach nurse has to manually
count old computer print-outs. This counting was done for evaluation purposes. A total of 37 clients completed immunization against hepatitis B in 1997, and a further 14 by June 1998.

Forty-five clients (45/99) from the client survey reported being ‘immunized’ against hepatitis B. I did not ask them if they had been given all three doses, nor did I ask if they had been immunized by the Street Outreach nurse. I suspect most had been immunized by Public Health because the vaccine costs $75.00 for a series of three doses when obtained from sources other than Public Health.

4.1.6.3 Number of Clients Testing Positive

a) Syphilis, and Hepatitis B and C Screening Tests

Testing positive for syphilis, hepatitis B antigen and hepatitis C antibody is reportable to Public Health and clients are followed up as mandated by provincial legislation. Testing positive for hepatitis B antibody indicates immunity if the antibody level is greater than 10 international units per litre. If someone tests positive for hepatitis B antibody, (s)he has been immunized or has had the infection. The incidence of hepatitis C among injection drug users is increasing at alarming rates. Table 4.3 illustrates the number of positive hepatitis C tests out of the total number of hepatitis C tests done by Street Outreach for the year 1997.

For the first quarter of 1998, the number of positive–hepatitis C antibody tests for the target group was three out of a total of seven positives done at the STD clinic. When reporting the prevalence of this type of infection in any population, one needs to consider
that the numbers are not always accurate because in order to be counted, people have to perceive themselves to be at risk and get tested. There are probably several injection drug using clients who are positive for hepatitis C, but have never been tested.

b) HIV Tests

In 1997 and to date in 1998, there have not been any HIV-positive test results in the Street Outreach clients who have been tested by PHS. Since anonymous HIV testing began in November 1993 there has been only one positive HIV test in those Street Outreach clients who have been tested by PHS. Although not asked on the client survey, three injection drug using clients reported being HIV-positive.

Table 4.3 Proportion of positive hepatitis C tests done by Street Outreach for 1997

<table>
<thead>
<tr>
<th>Month</th>
<th>Hepatitis C Antibody</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>1 (1/11)</td>
</tr>
<tr>
<td>February</td>
<td>0 (0/3)</td>
</tr>
<tr>
<td>March</td>
<td>0 (0/1)</td>
</tr>
<tr>
<td>April</td>
<td>1 (1/3)</td>
</tr>
<tr>
<td>May</td>
<td>2 (2/5)*</td>
</tr>
<tr>
<td>June</td>
<td>3 (3/9)</td>
</tr>
<tr>
<td>July</td>
<td>0 (0/1)</td>
</tr>
<tr>
<td>August</td>
<td>2 (2/8)</td>
</tr>
<tr>
<td>September</td>
<td>1 (1/3)</td>
</tr>
<tr>
<td>October</td>
<td>0 (0/5)</td>
</tr>
<tr>
<td>November**</td>
<td></td>
</tr>
<tr>
<td>December</td>
<td>1 (1/5)</td>
</tr>
<tr>
<td>Totals</td>
<td>11 (11/54) (20%)</td>
</tr>
</tbody>
</table>

*1 of the 5 tests was indeterminate (cannot determine positivity) and not included here as being positive.
** No tests were done by Street Outreach in November.
4.1.6.4 Observations of Testing/Immunizing

During the period of time I observed service delivery from the van, an opportunity did not arise whereby I could observe the Street Outreach nurse testing or immunizing a client. I am unable to provide a description of this procedure for this evaluation.

4.1.7 Description of Street Outreach Resources

The following section provides a brief overview of the resources currently used by the Street Outreach project. An in-depth cost-benefit analysis is beyond the scope of this evaluation. The information was provided by the Healthy Lifestyles Department manager along with other management records.

4.1.7.1 Staff Resources

a) Salaries

There are three staff persons providing services in Street Outreach: a full-time degree public health nurse and two .75 full-time equivalent outreach workers. According to the information provided by management, the budgeted salaries for both the nurse and outreach workers total $84,577.00. The cost of benefits adds a further 13% to 14% to the salaries listed. The budgeted amount listed here for both categories of workers seems low given the current salary rates and additional cost of benefits.

b) Qualifications

The latest job description for the outreach workers is dated October 1997. The following qualifications for the position were requested:
Knowledge, Abilities, and Skills:

- ability and experience working with street involved people and the street environment
- self-starting, mature, ability to work co-operatively
- nonjudgmental re: injection drug users and sexual preference behaviour and empathetic to clients’ environment, culture and needs
- willingness to work variable shifts, including evenings and weekends
- valid drivers’ licence

Education, Training and Experience

- post secondary training in an area related to HIV/STD prevention program preferred (e.g., human services or health care field)
- understanding of Aboriginal culture

The latest job description for the Public Health nurse is dated Spring 1995 and the following qualifications for the position were posted:

Knowledge, Abilities, and Skills:

- knowledge of the principles, practice, techniques of community development and community health practice
- knowledge in healthy sexuality and in sexually transmitted disease
- ability to establish and maintain effective working relationships with professional, clerical staff and the general public
- ability to work with target population in non-judgmental manner
- ability to communicate effectively, orally and in writing

Education, Training and Experience

- Bachelor of Nursing
- one year community health nursing experience, additional training in community development
- registered with Saskatchewan Registered Nurses Association
- class 5 drivers’ licence
- personal vehicle

According to the qualifications for the positions, there seems to be a good fit between what was requested and what the staff brought to the positions. The Street Outreach nurse started with the program in December 1995. Prior to that time, she
worked in acute care in northern Saskatchewan and as a community health nurse with Medical Services Branch in a northern Cree community of about 3,000 people, a position she held for seven years. After completing her degree in nursing, she joined PHS as the Street Outreach nurse. Her background in northern community health nursing and familiarity with the Aboriginal population should certainly be of benefit to Street Outreach and the target population.

There are currently one casual and two permanent outreach workers with Street Outreach. At the time of the client surveys and observations for the evaluation, as explained earlier, one of the outreach workers was on educational leave. Again, the fit between what management wanted for the position and the qualifications of those filling the positions appears to be a good one. The outreach worker on leave is completing a post-secondary degree in social work. She has worked part-time with the program since 1993 and just spent four months at a treatment centre for addiction in Scotland. One of the outreach workers has extensive experience working with an international development agency. She attends the local university where she has been taking classes in community development, sociology and Native studies. She is active on committees working to get children off the streets. The third outreach worker moved recently to Saskatoon from Ontario where she spent five years as a counsellor at an Aboriginal Health Clinic in Toronto. One of her jobs at the clinic was facilitating clients into the appropriate program areas.

The outreach workers and the nurse appear to have the knowledge, abilities, skills as well as the education and training requirements requested for the positions. They are
all familiar with the Aboriginal culture and have the sensitivity required to work with the
target population. As indicated by the comments from the client surveys and from
observations, the staff are friendly, non-judgmental, respectful and caring.

4.1.7.2 Mobile Van

The budgeted amount for the van for the 1997/98 fiscal year (April 1 to March
31) was $4,000.00. This amount includes repair costs, safety assessment costs, license,
insurance and fuel costs. The actual costs for the 1997/98 year are not available as yet.

Fuel for the van appears to range from approximately $150.00 per month to as
high as $350.00 in winter months. Safety assessments and repairs include such things as
tune-ups or tire rotations. This amount totalled approximately $1,200.00 for the period
from May 1997 to February 1998. Insurance and licence costs were not shown
separately.

4.1.7.3 Supplies

Supplies for Street Outreach include condoms, syringes, needles, hazardous waste
containers, drugs/vaccines, and miscellaneous materials and supplies. These supplies are
not separated from the entire Sexual Health program budget. However, the cost for
needles and syringes and most of the hazardous waste containers would be Street
Outreach costs. The following table provides the budgeted amounts for supplies as they
pertain to the entire Sexual Health program, not specifically Street Outreach.

Although supplies such as needles for testing or latex gloves would be used by
Street Outreach, the majority of the supplies are used by the nurses in the other Sexual Health clinics and have not been included here. Also of note is the amount of money spent on condoms. The budgeted amount shown is less than the amount actually spent. Approximately $28,000 was spent on condoms in 1997/98. The reason for the increase over budget likely resulted from bulk purchasing. Large quantities of both Hardcover and Ramses condoms were ordered to save money. On the purchase of Ramses condoms alone, $582.20 was saved.

Table 4.4  Budgeted amounts for supplies used by Sexual Health for 1997/1998

<table>
<thead>
<tr>
<th>Supplies</th>
<th>Budgeted amount 1997/1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condoms</td>
<td>$22,550</td>
</tr>
<tr>
<td>Hazardous waste containers</td>
<td>1,800</td>
</tr>
<tr>
<td>Drugs/Vaccines</td>
<td>3,005</td>
</tr>
<tr>
<td>Syringes</td>
<td>12,500</td>
</tr>
</tbody>
</table>

4.1.7.4 Funding

As indicated in section 1.6.2, funding for Street Outreach comes from two sources: Saskatchewan Health and PHS. The provincial amount designated for needle exchange is $44,000 out of a total of $66,000 for Street Outreach. The balance of the funding needed to provide services is provided by PHS Healthy Lifestyles Department as discussed in the previous section (1.6.2, Current Services).
4.2 **Research Objective # 2 and Sub-Objectives**

*To describe the Street Outreach clients who are injection drug users and their risks for HIV, other blood-borne infections, and sexually transmitted diseases.*

2.1 To document the number of clients using needles.
2.2 To describe client sociodemographics.
2.3 To describe clients’ injection practices.
2.4 To describe clients’ sexual practices.
2.5 To describe clients’ knowledge of HIV, Hepatitis B and C, and sexually transmitted diseases.

The client statistical records for 1997 provided data required for the first process indicator. The following process indicators are the quantifiable measures for the first research objective.

- **4.2.1 Number of Clients Using Needles**

According to the 1997 Street Outreach data kept on clients accessing services, a total of 4,009 contacts were made; 2847 (71%) of those contacts involved the distribution or return of needles. Staff documented 425 different client numbers as making contact with Street Outreach during the year. Of those, 328 clients (77.2%) accessed needles. From the data recorded according to client number, 86 different clients received fewer than 50 needles in 1997, 24 clients received between 50 and 100 needles; 176 clients received between 100 needles (1 box) and 1000 needles, and 42 clients received more than 1000 needles (10 boxes) in 1997.
4.2.2 Description of Respondents’ Sociodemographic Characteristics

Table 4.5 provides descriptive findings from the demographic variables assessed. Fifty-nine females and forty-one males participated in the survey. Respondents ranged in age from 15 to 51 years old. The mean age was 29.5 and the median was 29 years (SD=8.8). Although females tended to be younger than the males, a Student’s t Test for independent groups did not determine a significant difference between them, ($t = -1.83$, $p=.93$). Chi-square tests were used to determine significant differences between males and females for the other demographic variables. None of the differences were significant.

Overall, most (75%) of the respondents were Aboriginal, lived in stable housing (fixed addresses), had a history of incarceration, and were unemployed. The majority had at least a junior high school level of education, with 53% having completed some high school, mostly grade 10. Half of the respondents reported being single, while a third reported living common-law. No one reported being in a relationship with a same sex partner.

Only 9% of respondents had lived in Saskatoon for less than one year, while a number (n=18) had lived their entire lives in Saskatoon. The mean and median number of years lived in Saskatoon were 12 years and 11.5 years (SD=9.69), respectively. Twelve percent (n=12) indicated that they had come to Saskatoon from Prince Albert (a smaller city north of Saskatoon) while 14% (n=14) had come from cities in Alberta. Others were from Moose Jaw (a small city in southern Saskatchewan), Regina, Vancouver and Saskatchewan Indian reserves.
<table>
<thead>
<tr>
<th>Demographic Variable</th>
<th>Males (N=41) n (%)</th>
<th>Females (N=59) n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;20 years</td>
<td>3 (7%)</td>
<td>13 (22%)</td>
</tr>
<tr>
<td>20-24</td>
<td>9 (22%)</td>
<td>8 (13%)</td>
</tr>
<tr>
<td>25-29</td>
<td>4 (10%)</td>
<td>14 (24%)</td>
</tr>
<tr>
<td>30-39</td>
<td>16 (34%)</td>
<td>16 (27%)</td>
</tr>
<tr>
<td>40+</td>
<td>9 (27%)</td>
<td>8 (13%)</td>
</tr>
<tr>
<td><strong>Level of Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary</td>
<td>1 (2%)</td>
<td>5 (9%)</td>
</tr>
<tr>
<td>Junior High</td>
<td>11 (27%)</td>
<td>22 (37%)</td>
</tr>
<tr>
<td>High School</td>
<td>25 (61%)</td>
<td>28 (48%)</td>
</tr>
<tr>
<td>Trade School</td>
<td>1 (2%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>University</td>
<td>3 (8%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td><strong>Ethnic Group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>13 (32%)</td>
<td>11 (19%)</td>
</tr>
<tr>
<td>Aboriginal/Status</td>
<td>27 (66%)</td>
<td>48 (81%)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (2%)</td>
<td></td>
</tr>
<tr>
<td><strong>Housing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apartment, duplex</td>
<td>38 (93%)</td>
<td>52 (88%)</td>
</tr>
<tr>
<td>Parent’s place</td>
<td>3 (7%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>Friend’s place</td>
<td></td>
<td>3 (5%)</td>
</tr>
<tr>
<td>Shelter</td>
<td>1 (2%)</td>
<td></td>
</tr>
<tr>
<td>No fixed address</td>
<td>1 (2%)</td>
<td></td>
</tr>
<tr>
<td><strong>Relationship Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>4 (10%)</td>
<td></td>
</tr>
<tr>
<td>Common Law</td>
<td>13 (32%)</td>
<td>23 (39%)</td>
</tr>
<tr>
<td>Divorced/Separated</td>
<td>2 (5%)</td>
<td>3 (5%)</td>
</tr>
<tr>
<td>Single</td>
<td>22 (54%)</td>
<td>30 (51%)</td>
</tr>
<tr>
<td><strong>History of Incarceration</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>41 (100%)</td>
<td>55 (93%)</td>
</tr>
<tr>
<td><strong>Employment Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regular</td>
<td>1 (2%)</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>Casual</td>
<td>5 (12%)</td>
<td>4 (7%)</td>
</tr>
<tr>
<td>Not employed</td>
<td>35 (85%)</td>
<td>53 (90%)</td>
</tr>
</tbody>
</table>
As explained earlier, little information is gathered about the total population. From the client statistical information available for 1997, there were more contacts made with females than males: 2400 and 1381, respectively. There were four contacts listed as ‘unknown,’ indicating that the staff were unable to determine the gender of the contacts. Both the number of males and females are underrepresented according to this information. Data on age and ethnic background of the clients are approximated by the staff, making the accuracy of results questionable. According to this data, however, the majority of clients ranged in age from 15 to 29 years old and approximately three quarters (73%) were documented as being Aboriginal.

4.2.3 Description of Respondents’ Injection Practices

In order to measure clients’ risks for HIV and hepatitis B and C, the following were assessed: initiation into injection drug use; types of drugs used; injection drug use patterns measured by frequency of injection, needle and equipment sharing behaviours, cleaning and disposal practices, the social context of injection drug use; and, needle exchange practices.

a) Initiation into injection drug use

Respondents reported having started to use needles as early as 11 years of age. The age range for this variable was 11 to 42 years, with 67% having used needles by the age of 20. The mean age for initiation into needle use was 19.5 years, and the median was 17 years (SD 6.46). Males and females did not differ in the age they began injecting, (t = -.55, p = .66).

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Respondents reported having used needles a mean of 8 years, median 5 years (SD 7.38). Almost half of them (47%) had been using needles for 1 to 5 years, 24% for 6 to 10 years, and 24% for more than 10 years. The shortest length of time reported was 4 months and the longest length of time was 32 years.

The majority of respondents (70%) indicated that they began using needles because their friends or partners introduced them to it. The desire to experiment or curiosity was also identified as a motivating factor. Appendix H provides an account of some of the stories I heard from survey participants when asked this question. The results clearly show that social networks have a great deal to do with initiation into needle use.
b) Types of Drugs Used

The majority of respondents (96%) reported trying different types of injection
drugs during their drug use history and some indicated trying “every kind of needle dope”
available. It is evident that in Saskatoon, prescription drugs are currently the most
popular and most often used. Almost half (48%) of the respondents indicated that they
had used morphine the most, while 46% preferred ritalin. Female respondents reported
using ritalin more than the male respondents, but the difference was not significant.
Thirty-two per cent of all respondents indicated that they had used cocaine the most and
another 25% indicated that they had used dilaudid or “dillies” the most. Thirty-six
respondents indicated that they had used at least two different drugs. Table 4.6 shows the
drugs respondents reported injecting, which ones they reported injecting the most, and
which ones they used on a regular basis over the past six months of their regular drug use.

Only two respondents reported having injected speedballs (heroin and cocaine).
Crack cocaine was reported as being used on a regular basis by only six respondents.

c) Frequency of Injection

Thirty-four per cent of respondents reported using needles the same day that the
interview was conducted. Twenty-eight per cent reported using needles from 1 to 3 days
prior to the interview, while 23% reported not using for 4 days to 2 weeks prior to the
interview. Eight reported not having used needles for a period of 1 to 6 months before
being interviewed.
Table 4.6 Drugs injected by respondents

<table>
<thead>
<tr>
<th>Drug</th>
<th>% of respondents who report having injected this drug</th>
<th>% of respondents who report injecting this drug the most</th>
<th>% of respondents who report injecting this drug on a regular basis in past six months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>88</td>
<td>48</td>
<td>66</td>
</tr>
<tr>
<td>Ritalin</td>
<td>88</td>
<td>46</td>
<td>73</td>
</tr>
<tr>
<td>Cocaine</td>
<td>86</td>
<td>32</td>
<td>40</td>
</tr>
<tr>
<td>Heroin</td>
<td>42</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Talwin</td>
<td>35</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Dilaudid</td>
<td>25</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Amphetamines (Speed)</td>
<td>19</td>
<td>1</td>
<td>+</td>
</tr>
<tr>
<td>Talwin and Ritalin</td>
<td>16</td>
<td>*</td>
<td>+</td>
</tr>
<tr>
<td>Others (Demerol, barbiturates, )</td>
<td>96</td>
<td>11</td>
<td>+</td>
</tr>
</tbody>
</table>

* Not indicated as drug used the most by anyone.
† Not asked or indicated by respondents as a drug used regularly.

Note: % is greater than 100 because respondents were allowed more than one response.

Most respondents reported fixing several times per day, with over one third (35 respondents) fixing at least once every day of the month. Table 4.7 presents the frequency of injection use. Frequency of daily injections ranged from 0 to 100 times per day, the number of days per week respondents injected ranged from 0 to 7, and the number of days per month respondents injected ranged from 1 to every day.
Table 4.7 Reported frequencies of injection drug use during past six months

<table>
<thead>
<tr>
<th># injections reported/day</th>
<th># of respondents (N=97)</th>
<th># days/week # of respondents reported injecting</th>
<th># of respondents (N=100)</th>
<th># days/month # of respondents reported injecting</th>
<th># of respondents (N=99)</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 5 times/day</td>
<td>53</td>
<td>≤ 1 day/week</td>
<td>7</td>
<td>1-7 days/month</td>
<td>16</td>
</tr>
<tr>
<td>6-10 times/day</td>
<td>21</td>
<td>2-3 days/week</td>
<td>17</td>
<td>8-14 days/mo</td>
<td>7</td>
</tr>
<tr>
<td>11-30 times/day</td>
<td>19</td>
<td>4-6 days/week</td>
<td>26</td>
<td>15-21 days/mo</td>
<td>27</td>
</tr>
<tr>
<td>≥ 35 times/day</td>
<td>4</td>
<td>7 days/week</td>
<td>50</td>
<td>≥ 22 days/month</td>
<td>49</td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>9 (12.6)</td>
<td>Mean (SD)</td>
<td>5 (2.1)</td>
<td>Mean (SD)</td>
<td>21 (9.28)</td>
</tr>
<tr>
<td>Median</td>
<td>5</td>
<td>Median</td>
<td>6.5</td>
<td>Median</td>
<td>21</td>
</tr>
</tbody>
</table>

Note: The frequencies are less than 100 because 3 clients were unable to say how many times per day they injected, but they were able to answer the number of times they injected per week and per month. One client was unable to answer how many days per month she injected because she said it depended on whether or not she had money to do so.

Other drug use was not assessed in this survey, except for alcohol and solvents.

Seventy-two per cent of the respondents interviewed indicated that they did not currently use alcohol 'on a regular basis.' Eighty-eight per cent of the respondents also reported that they had never used solvents on a regular basis. Of the twelve who indicated some solvent use, many commented that they had done so when they were younger.

d) Needle Sharing Behaviours

Fifty-three per cent of respondents reported that they had at some time used a needle that someone else had used. Three reported that they were unsure. The difference between males and females sharing needles was tested for significance using a Chi-square test. The difference was not statistically significant. Although over half of the 126
respondents reported having used needles that had been used by someone else, only 24% reported having done so in the past six months. Among this group two thirds did not always clean the needles used by someone else before using them. Table 4.8 shows the frequency with which respondents shared needles and cleaned needles before using them within the past six months.

Table 4.8 Needle sharing and cleaning behaviours within past six months

<table>
<thead>
<tr>
<th>Frequency of reported sharing</th>
<th>Number of respondents (N=23)</th>
<th>Frequency of reported cleaning</th>
<th>Number of respondents (N=23)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>_</td>
<td>Always</td>
<td>8</td>
</tr>
<tr>
<td>Usually</td>
<td>3</td>
<td>Usually</td>
<td>6</td>
</tr>
<tr>
<td>Sometimes</td>
<td>6</td>
<td>Sometimes</td>
<td>4</td>
</tr>
<tr>
<td>Hardly Ever</td>
<td>14</td>
<td>Hardly Ever</td>
<td>2</td>
</tr>
<tr>
<td>Never</td>
<td>_</td>
<td>Never</td>
<td>3</td>
</tr>
</tbody>
</table>

Note: One respondent reported sharing needles within the past six months but did not answer how often this had happened making the total N=23 instead of 24.

Two HIV-positive respondents reported that they had used needles that someone else had used within the past six months. One indicated that this had happened ‘hardly ever’ and she always cleaned the needle before using it; however, if bleach was not available, she just used water. Another HIV-positive respondent reported that in the past six months, she, too, had used a needle that had been used by someone else. She indicated that she “always” cleaned the needle with bleach before re-using it. She commented that she re-used the needles because she “knows the people are clean” and there were no other needles available.
When survey participants were asked why they had used a needle which had been used by someone else, the majority (n=16/23) responded that it was the only needle available or that they had shared with a loyal partner, or both. One respondent reported sharing the needle because she had split the drug (a process whereby one person injects half of the drug and passes on the syringe with the other half of the drug for the next person to use). Other comments included being on cocaine and not knowing whether or not they were sharing needles, sharing by accident, or assuming the other people were 'clean' and needing a fix.

Respondents who reported having shared needles were asked with whom they had shared. Twenty-six per cent indicated that they had used a needle that their friends or relatives had used before; twenty-three per cent had used a needle that their partners had used before. Three people indicated having used a needle that had been used before by strangers, three others by friends and partners, while another four respondents had used needles that had been used by friends, partners and strangers.

The majority of the respondents (n=52) indicated that they had let someone else use a needle that they had used, while 43 indicated they had never done so. Although respondents were not asked who else had used the needle, most indicated when answering that it was their partners or friends who had used the needle after they did.

Ninety-three per cent of the respondents reported that they would not share needles if there were always new needles available. Four respondents indicated that they would share needles if they were cleaned first, two respondents thought they might if they were doing cocaine, and one client indicated she might if she were splitting the drug with
her partner.

The majority (n=70) of survey participants did not use needles when they were incarcerated. Sixteen indicated that they had used needles that someone else had used while incarcerated and 15 of those 16 had cleaned the needle before using it. Five respondents used water to clean the needle with, five used bleach, three used a combination of water and bleach, one used alcohol and another used Comet cleanser.

Cleaning Needles

Although using a new needle for each injection is recommended, using a needle that has been cleaned properly is less risky than using one that has not been cleaned. The recommended method for cleaning a dirty needle is to fill the syringe with clean water at least three times, discarding the water after each fill. The syringe should then be filled with bleach 3 times, leaving the bleach in the syringe for at least 30 seconds each time before discarding. It is also recommended to shake the syringe and to tap the sides of the barrel while the bleach is in the syringe in case blood is adhered to the inside of the barrel or hub of the needle. Finally, the syringe should be rinsed with clean water at least three times before re-using.

One quarter (n=25) of the respondents reported using new needles each time they injected and never having to clean their needles. The majority (n=66) reported using bleach and water to clean their needles. The most common method for cleaning was to rinse the needle with bleach (commonly called Javex) three times and rinse with water three times. The length of time the solution was left in the syringe varied from a couple of seconds to ten minutes. A few respondents reported shaking the syringe while the
bleach was inside the barrel; no one reported ‘shaking’ and ‘tapping’ which is preferred. Seven respondents knew to rinse with water first, then with bleach followed by clean water again. Several (n=8) reported rinsing with bleach followed by water, but only for one or two repetitions. At least three respondents indicated that they used a water and bleach solution instead of full-strength bleach. A respondent who is hepatitis C-positive reported that he uses either bleach or water to clean his needles, but if he notices blood in the syringe he cleans with bleach.

Four respondents who reported using only water to clean their needles, indicated that they did so because they re-used their own needles. One reported wringing out the alcohol from alcohol swabs into a spoon and then rinsing the needle with that. Another reported using vinegar and water to clean the needle.

One of the HIV-positive respondents indicated that she cleaned needles with water if bleach was not available before she used a needle that someone else had used. She commented, “I’m sick and can’t get any sicker and there were no new ones (needles) around.” She also indicated that she would not let someone else use a needle that she had already used.

**Disposal of Needles**

The recommended way of disposing of a dirty needle is to break off the point and to deposit the syringe and the needle into a puncture-proof container. Breaking off the point discourages people from going through the containers and re-using dirty needless when new ones are not available. If clients do not have proper disposal containers, they can break off the point and put it into the barrel of the syringe and then place the syringe
inside a pop bottle or tobacco tin. Breaking off the point is not recommended if clients do not dispose of them in puncture-proof containers. If clients dispose of the points in the regular garbage instead of into puncture-proof containers, garbage collectors are at increased risk for needle stick injuries. Recapping the needle is not recommended unless it is the person's own needle also due to the risk of needle stick injuries. The risk results if the needle was used by someone else who was infected with HIV, hepatitis B and/or hepatitis C and another person accidentally gets poked by the contaminated needle.

Over three quarters (n=84) of the respondents indicated that they disposed of their used needles in the safety containers provided by the Street Outreach staff. Thirteen indicated that they throw their used needles in the garbage. Most (n=68) recap the needle before disposing of them. Some (n=9) break the point off before disposing of them in the containers.

e) Sharing Injection Equipment

A large number of respondents (n=62) reported sharing other injection equipment. Thirty-five reported that they never shared injection equipment, while one client was not sure or could not remember. No gender differences were found for this variable. Table 4.9 shows the number of respondents who reported sharing injection equipment. Table 4.10 shows how often respondents reported sharing injection equipment during the past six months.
Table 4.9  Number of respondents who reported sharing injection equipment

<table>
<thead>
<tr>
<th>Injection Equipment</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spoons</td>
<td>57</td>
</tr>
<tr>
<td>Water</td>
<td>44</td>
</tr>
<tr>
<td>Cotton/filters</td>
<td>31</td>
</tr>
<tr>
<td>Syringes (not needles)</td>
<td>28</td>
</tr>
<tr>
<td>Wash</td>
<td>8*</td>
</tr>
</tbody>
</table>

*Not asked on the survey, only reported if mentioned by respondent.
Note: Respondents could answer more than once.

Table 4.10  Frequency of sharing injection equipment during the past six months

<table>
<thead>
<tr>
<th>Frequency reported sharing equipment</th>
<th>Number of respondents (%) (N=62)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>7 (11%)</td>
</tr>
<tr>
<td>Usually</td>
<td>8 (13%)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>13 (21%)</td>
</tr>
<tr>
<td>Hardly ever</td>
<td>12 (19%)</td>
</tr>
<tr>
<td>Never</td>
<td>22 (36%)</td>
</tr>
</tbody>
</table>

The two HIV-positive respondents reported having shared spoons, water, syringes and in one case, the wash. Neither had done so within the past six months. Both indicated that they had not shared their equipment since finding out about their HIV status.

f)  Social Context of Injection Drug Use

Respondents reported usually using needles in groups with others. Only 11 indicated that they were alone when they fixed, while most (n=72) indicated that they were usually with one to three others. Sixteen indicated they fixed in the presence of four or more people. Some of the older respondents said there may be others present when
they fix, but they go to the bathroom or somewhere private so that they can fix without anyone looking.

The majority (n=92) of respondents indicated that they did not usually use in groups with strangers. Eight indicated that in some situations they did use with strangers, for example, one client commented that he might fix with a stranger at the dealer’s. Others commented that they might fix with strangers at a party or if they were so ‘wrecked’ that they did not know they were strangers. Two respondents indicated that they would share a needle with strangers if they had to or if they were using ‘blow’ (cocaine).

Seventy-eight respondents indicated that they have injected in cities other than Saskatoon. The cities mentioned most frequently were Edmonton, Calgary, Regina and Prince Albert; these were also the ones that clients mentioned visiting most recently. Respondents often listed two or three different cities where they had injected. Although it is difficult to assess the timeframe for this type of movement, it is clear that there is movement between cities and that injection drug users continue to use injection drugs wherever they go.

g) Needle Exchange Practices

The majority (n=92) of the clients interviewed indicated that their source for new needles during the past six months was the Street Outreach van. Table 4.11 illustrates where respondents reported getting new needles in the last six months.
Table 4.11  Source of new needles by location

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of respondents (N=99)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile van</td>
<td>92</td>
</tr>
<tr>
<td>Friends</td>
<td>31</td>
</tr>
<tr>
<td>STD clinic</td>
<td>22</td>
</tr>
<tr>
<td>Hewgill's Pharmacy</td>
<td>16</td>
</tr>
</tbody>
</table>

Note: One respondent accessed other services from Street Outreach, but had not accessed needles and did not indicate getting needles from ‘friends’. Totals are more than 99 because respondents could give more than one answer.

Table 4.12 illustrates the reasons offered by respondents when asked why they usually get needles from the location indicated.

Table 4.12  Reasons offered for location preference for obtaining new needles

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Number of respondents (N=100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convenient</td>
<td>50</td>
</tr>
<tr>
<td>Free</td>
<td>32</td>
</tr>
<tr>
<td>Safety issues</td>
<td>27</td>
</tr>
<tr>
<td>Staff</td>
<td>16</td>
</tr>
<tr>
<td>Confidential</td>
<td>12</td>
</tr>
</tbody>
</table>

Note: Total number of responses is greater than 100 because respondents could give more than one answer.

Most of the respondents (n=73) indicated that they did not find it hard to get new needles. The two most common reasons offered related to accessibility: Someone was always around who had access to new needles or they found it easy to get them from the Street Outreach mobile van. Others commented that they “stocked up” so that they always had new needles on hand. For those who indicated that it was hard to get new
needles (n=27), the most common answer given related to inaccessibility: The Street Outreach van was not always around or nothing was open, making it difficult to get new needles when they were needed.

The number of needles that respondents got at each visit varied. Almost half (n=40) obtained at least a box of 100 needles each visit. The number of needles ranged from 1 to 600 with a mean of 122 needles and a median of 100. Over one quarter (n=26) of the respondents got between 150 and 600 needles per visit. Most (n=73) also reported getting needles for others. Twenty-nine reported getting needles for one to two other people, while thirty-four respondents reported getting needles for as many as three to ten others and seven reported getting needles for more than ten other people. Of those who reported getting needles for others, over half (n=58, 58/74) indicated that they got new needles for their friends and acquaintances or relatives. Some respondents (n=16, 16/74) got needles for their partners or both their partners and friends. This finding supports the secondary distribution of needles and the social context within which injection drug use occurs.

Respondents were asked if they knew other injection drug users who did not use the Street Outreach needle exchange service. Half (n=50) indicated that they did know others who did not use the service. They speculated that the reasons these people did not use the needle exchange related to the type of people they were (e.g., shy, embarrassed about being a “junkie”), being scared of the police or having their “names on a list somewhere,” having other means to access needles (e.g., buying them), or in some cases because people did not know about the program.
Almost half (n=45) of the survey participants interviewed had been in a treatment centre in Saskatoon for their addiction problems. Seventeen reported currently being in the methadone maintenance program, which began in Saskatoon in the summer of 1997. All of those currently in the methadone program, as well as eight others who had been in a rehabilitation or detoxification centre previously, reported that they had received the help they needed. Respondents commented that the rehabilitation or detoxification centres were helpful for their drinking problems, but not particularly helpful for injection drug use. One respondent shared that it was in a treatment centre that she learned how to inject drugs.

Comments from respondents about the methadone maintenance program were very positive. There were no comments about waiting for any length of time to get on the program. Those on the program had this to say about it:

"Methadone maintenance is helping extremely. It’s changed my whole life around. (I) got my kids and husband back. (I) don’t crave drugs anymore.”

"Until this methadone program, (I) thought there wasn’t any hope. Methadone is a miracle drug.”

"Methadone helps me to be normal. (I’m) saving money, getting sex life again, doing housework again.”

"Methadone gives me some control. (It’s) making my life normal.”

Table 4.13 illustrates the kinds of treatment centres that clients reported being in for addiction problems.

Respondents indicated that they had been referred to the different treatment centres by a variety of ways which included self-referrals, family, friends, psychiatrists,
Corrections, and social workers.

Table 4.13  Treatment centres in Saskatoon attended by respondents

<table>
<thead>
<tr>
<th>Type of centre</th>
<th>Number of respondents (%) (N=43)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone Maintenance</td>
<td>17 (40%)</td>
</tr>
<tr>
<td>Detoxification centre</td>
<td>13 (30%)</td>
</tr>
<tr>
<td>Rehabilitation centre</td>
<td>9 (21%)</td>
</tr>
<tr>
<td>More than one type</td>
<td>7 (16%)</td>
</tr>
<tr>
<td>Native healing</td>
<td>1 (2%)</td>
</tr>
</tbody>
</table>

h) Other Information Related to Injection Practices

Respondents' perceived risk for HIV was assessed. Ten per cent saw themselves at high risk for HIV, 21% saw their risk as about 'average,' while 54% felt their chance of becoming infected with HIV was 'low,' and 13% considered themselves to be at 'no risk.' Even 28% of those who had shared injection equipment and 10% of those who had used a needle that someone else had used, believed that their chances of becoming infected with HIV was 'pretty low.' Only 14% of those who shared equipment or needles rated themselves at 'pretty high' risk for becoming infected with HIV. Two clients disclosed being HIV-positive; after the interview process one more client disclosed being HIV-positive, bringing the total to three.

Respondents were asked how good they thought their memory was for the preceding questions since using psychoactive drugs affects memory. The majority (70%) judged their memory to be 'pretty good' or 'really good,' while 26% thought their memory was 'not bad.' Only 4% thought their memory was poor.
4.2.4 Description of Respondents' Sexual Practices

In order to measure risk of spreading HIV by sexual activity, respondents were asked about the number of sexual partners and condom use.

Almost all of the respondents (n=91) responding to the survey reported having sexual partners within the past six months. Eleven respondents, all females, reported having exchanged sex for drugs or a place to sleep in the past six months, while 30 reported having been paid for sex within the past six months. One of the respondents responding positively to the question about being paid for sex was male, while the others were female. The male respondent indicated that he had only female sexual partners.

Eight female respondents indicated that they had both male and female sexual partners. One of these had reported being paid for sex within the past six months. None of the male respondents reported having same sex partners.

4.2.4.1 Number of Sexual Partners

The number of sexual partners was assessed for three periods: the past month, the past year, and lifetime. The number of lifetime partners ranged from 1 to over 2,000. This was a difficult question for the sex trade workers to answer. Many did not consider their ‘tricks’ to be sexual partners and when asked to do so, they could only guess at the number there may have been. One sex trade worker commented, “uncountable. When you’re a hooker you don’t count.” Table 4.14 illustrates the number of sexual partners respondents reported having within the past month, past year and their lifetime.

Student’s t-Tests on the logarithmic transformations for the variables assessing the
number of sexual partners over the three time periods were conducted. There were no significant differences between males and females for the number of sexual partners reported during the past month ($t[-1.03], p=.365$) or the number of lifetime partners ($t[.85], p=.087$). However, there were significant differences between males and females for the number of partners in the past year ($t[-1.42], p=.008$).

Table 4.14  Number of sexual partners reported by gender

<table>
<thead>
<tr>
<th>Gender</th>
<th># partners/ month</th>
<th>number of respondents</th>
<th># partners/ year</th>
<th>number of respondents</th>
<th># partners/ lifetime</th>
<th>number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(N=55)</td>
<td></td>
<td>(N=55)</td>
<td></td>
<td>(N=54)</td>
</tr>
<tr>
<td>Females</td>
<td>0</td>
<td>10</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>23</td>
<td>1</td>
<td>12</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2-5</td>
<td>11</td>
<td>2-5</td>
<td>13</td>
<td>2-5</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>6-10</td>
<td>3</td>
<td>6-10</td>
<td>5</td>
<td>6-10</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>11-25</td>
<td>3</td>
<td>11-25</td>
<td>4</td>
<td>11-25</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>26-75</td>
<td>4</td>
<td>26-75</td>
<td>10</td>
<td>26-75</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>100+</td>
<td>1</td>
<td>100+</td>
<td>7</td>
<td>100+</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Mean</td>
<td>7</td>
<td>33</td>
<td>210</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(N=40)</td>
<td></td>
<td>(N=40)</td>
<td>(N=39)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>0</td>
<td>8</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>21</td>
<td>1</td>
<td>14</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>2-5</td>
<td>11</td>
<td>2-5</td>
<td>17</td>
<td>2-5</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>6-10</td>
<td>0</td>
<td>6-10</td>
<td>3</td>
<td>6-10</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>11-25</td>
<td>0</td>
<td>11-25</td>
<td>2</td>
<td>11-25</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>26-75</td>
<td>0</td>
<td>26-75</td>
<td>2</td>
<td>26-75</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>100+</td>
<td>0</td>
<td>100+</td>
<td>100+</td>
<td>100+</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Mean</td>
<td>1</td>
<td>5</td>
<td>74</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Some respondents were unable to estimate the number of sexual partners or give a range for this question and have been treated as missing.
Overall, males had fewer sexual partners than did the females. The difference between the number of sexual partners reported by males and females is even more evident when looking at the mean for each group as illustrated in Table 4.14. The female respondents reported having more sexual partners during the last year than did the male respondents. The numbers ranged from 0 to 300 for the females and 0 to 50 for the males. These differences were not surprising given the number of female sex trade workers who responded to the survey.

Of concern from the data presented in Table 4.14 was the number of females (40%) and males (28%) who had more than one sexual partner in the past month. Those numbers rose to 71% of females and 60% of males who reported more than one sexual partner in the past year.

Table 4.15 illustrates the mean number of sexual partners reported according to respondents' age. As shown, overall the number of sexual partners decreases with the age of the client. Younger respondents tend to have had more sexual partners. Forty-four (23 females and 21 males) reported having only one sexual partner in the past month. Those numbers dropped to 12 females and 14 males who reported having only one sexual partner in the past year.

Interestingly, 11 males and 7 females reported not having any sexual partners who were injection drug users. Thirty-six per cent (21/58) of the females and 15% (6/40) of the males reported having only one sexual partner who had been an injection drug user. The range for this variable was 0 to 100 for the female clients and 0 to 40 for the male clients. Some respondents commented that 'most' or 'all' of their sexual partners had
been injection drug users and could not be counted.

Table 4.15  Mean number of sexual partners according to respondent age

<table>
<thead>
<tr>
<th># Sexual Partners</th>
<th>Respondent Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>≤19 Yrs</td>
</tr>
<tr>
<td>Mean # sexual partners/month</td>
<td>8.9</td>
</tr>
<tr>
<td>Mean # sexual partners/year</td>
<td>53.1</td>
</tr>
<tr>
<td>Mean # sexual partners/lifetime</td>
<td>167.6</td>
</tr>
</tbody>
</table>

Note: When respondents indicated a range for sexual partners, the mid-range number was used in this calculation. For example, if the number of sexual partners was 100-200, 150 was used. If a range was not specified, the value was considered missing.

4.2.4.2 Description of Respondents’ Self-Reported Condom Use

As shown in Table 4.16, reported condom use varied. Overall, condoms were used more often with casual partners than with regular partners. Casual partners were defined as those with whom the respondent had a sexual relationship with for less than three months, while regular partners were defined as those with whom the respondent had a sexual relationship with for at least three months. Although 7% of respondents did not use condoms for vaginal intercourse with their casual partners, this figure rose to 60% with regular partners. In the case of anal and oral sex, condoms were used more often with casual partners than with regular partners. There is little difference between age groups regarding condom use. Those less than 19 years old reported ‘always’ using condoms for vaginal intercourse more often than did the other groups for both regular and casual partners. Male and female respondents did not differ significantly in condom use for vaginal or oral sex with regular partners.
Table 4.16  Condom use by type of partner and type of sex

<table>
<thead>
<tr>
<th>Type of Partner</th>
<th>Type of sex</th>
<th>Number of respondents using condoms (%)</th>
<th>Frequency of condom use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular</td>
<td>Vaginal</td>
<td>35 (35/85) (41%)</td>
<td>Always 14(14/35)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mostly 12(12/35)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hardly ever 9(9/35)</td>
</tr>
<tr>
<td></td>
<td>Anal</td>
<td>8 (8/14) (57%)</td>
<td>Always 6(6/8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mostly 1(1/8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hardly ever 1(1/8)</td>
</tr>
<tr>
<td></td>
<td>Oral</td>
<td>24 (24/74) (32%)</td>
<td>Always 13(13/24)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mostly 7(7/24)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hardly ever 4(4/24)</td>
</tr>
<tr>
<td>Casual</td>
<td>Vaginal</td>
<td>56 (56/60) (93%)</td>
<td>Always 44(44/56)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mostly 8(8/56)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hardly ever 5(5/56)*</td>
</tr>
<tr>
<td></td>
<td>Anal</td>
<td>7 (7/8) (88%)</td>
<td>Always 7(7/7)</td>
</tr>
<tr>
<td></td>
<td>Oral</td>
<td>44 (44/58) (76%)</td>
<td>Always 38(38/44)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mostly 5(5/44)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hardly ever 1(1/44)</td>
</tr>
</tbody>
</table>

*One respondent responded that he did not have vaginal intercourse with casual partners, but responded ‘hardly ever’ for frequency of condom use for vaginal sex with casual partners.

Note: The denominators reported are the same as the number of respondents who reported having each type of sex.
a)  Condom Use According to Gender

More male respondents reported using condoms for anal sex with their regular partners than did female respondents. On the other hand, condom use for oral sex with casual partners was higher for females than for males, likely due to the number of sex trade workers responding in this survey. More females than males reported not using condoms for vaginal sex with their regular partners. Condom use for oral sex with regular partners was similar for both genders.

b)  Sexual Practices and Condom Use for Respondents Who Had Been Paid for Sex Within the Past Six Months

Condom use for respondents who had responded that they had been paid for sex within the past six months was examined. Sixty-seven per cent reported not using condoms for vaginal sex with their regular partners, while 97% (29/30) reported using condoms for vaginal sex with their casual partners; the other respondent reported not having vaginal intercourse with casual partners. Two of three respondents from this group reported using condoms 'always' or 'most of the time' for anal sex with regular partners. One from this group reported not using condoms for anal sex with regular partners. Two of three respondents reported always using condoms for anal sex with casual partners, while one reported not using condoms at all for anal sex with casual partners.

Of the 28 respondents reporting oral sex with casual partners, 26 used condoms: 23 always used them, 2 used condoms most of the time, and 1 hardly ever used them. This rate was higher than the rate reported for all 100 respondents. Condom use with
regular partners for oral sex was similar to the rates reported in Table 4.16 for all clients. Four of 22 respondents who had been paid for sex within the past six months reported ‘always’ using condoms for oral sex, and 2 reported using condoms ‘most of the time,’ while 16 of the 22 did not use condoms for oral sex with their regular partners.

The reasons offered by respondents for not using condoms did not differ greatly between those who had been paid for sex within the past six months and the whole sample. Overall, 58% (46/79) indicated that they did not use condoms because they were in a trusting relationship. Other reasons offered included: self or partner not liking them (16/79); drunk or high at the time (7/79); none available (4/79); heat of the moment (2/79); “don’t know” (2/79); trying to get pregnant (1/79); and partner is in jail (1/79).

4.2.5 Description of Respondents’ Knowledge Related to HIV, Hepatitis B and C, and STDs

Clients’ knowledge about HIV, hepatitis B and C, and other sexually transmitted infections was assessed. While knowledge alone is not sufficient to change risky behaviour, risk reduction is unlikely to occur in the absence of awareness.

a) Knowledge of Sexually Transmitted Diseases

The majority of respondents were knowledgeable about the symptoms of some of the more common STDs. Common symptoms such as discharge, pain on voiding, ulcers and bumps in the genital area were recognized. Over three quarters (80%) were aware that discharge and pain on voiding are symptoms of an STD, while 75% recognized that ulcers in the genital area were also symptoms of an STD. Only 56% (n=52) identified
‘bumps in the genital area’ as a symptom of genital warts, a common sexually transmitted infection. This finding may have been due to the word ‘bumps.’ Although it was not obvious in pretesting the questionnaire, many respondents were puzzled by the use of the word. Other symptoms most commonly mentioned included: itchiness, smell or odour, abdominal pain or cramps, and weight loss.

b) Knowledge of HIV

Knowledge about transmission of HIV was assessed by an open-ended question on the survey and respondents were fairly well informed. Table 4.17 illustrates the most commonly reported means of transmission cited by respondents.

Some misconceptions were reported: Five respondents specifically mentioned that HIV could not be transmitted through oral sex, while six others thought HIV could be transmitted through saliva or toothbrushes, and as a result of not knowing your sexual partners. Only one respondent mentioned homosexual sex as a means of transmission. One respondent commented that HIV transmission through sharing needles was not as risky as sexual intercourse.

Knowledge on how to protect oneself from HIV was even higher. Respondents who did not specifically mention ‘unprotected’ sex as a means of HIV transmission did indicate that to protect oneself required using condoms. The two most frequently mentioned ways to prevent getting HIV were using condoms (89%) and not sharing needles (80%). Most identified both. Seventeen per cent suggested a monogamous relationship or not having sex, while another 4% suggested not sharing injection drug equipment as prevention strategies.
Table 4.17  Means of HIV transmission

<table>
<thead>
<tr>
<th>Means of transmission</th>
<th>Frequency of response (N=100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharing needles</td>
<td>76</td>
</tr>
<tr>
<td>Vaginal sex (unspecified)*</td>
<td>51</td>
</tr>
<tr>
<td>Anal sex (unspecified)</td>
<td>43</td>
</tr>
<tr>
<td>Oral sex (unspecified)</td>
<td>37</td>
</tr>
<tr>
<td>Blood, body fluids</td>
<td>36</td>
</tr>
<tr>
<td>Unprotected sex (oral, vaginal &amp; anal)</td>
<td>30</td>
</tr>
<tr>
<td>Through needles, injection drugs</td>
<td>10</td>
</tr>
<tr>
<td>Unprotected anal sex</td>
<td>6</td>
</tr>
</tbody>
</table>

* Unspecified means they did not specifically say 'unprotected' or 'protected' sex.

Note: Total more than 100 because more than one answer was allowed.

c) Knowledge of Hepatitis B and C

Respondents' level of knowledge about hepatitis B and C transmission was considerably lower than that pertaining to transmission of HIV. They appeared to be slightly more informed about hepatitis C transmission than hepatitis B: Forty per cent of respondents were unsure how hepatitis B was transmitted, whereas only 20% were unsure how hepatitis C was transmitted. The most common means of transmission mentioned for both were sharing needles and sexual intercourse. Blood was mentioned more frequently as a means of transmission for hepatitis C. The finding that respondents often mentioned lack of cleanliness or hand washing as another means of transmission suggests that hepatitis B and C are confused with hepatitis A. Table 4.18 illustrates the responses regarding transmission of hepatitis B and C.
Table 4.18 Means of transmission for Hepatitis B and C

<table>
<thead>
<tr>
<th>Means of transmission</th>
<th>% responses for hepatitis B</th>
<th>% responses for hepatitis C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsure</td>
<td>40</td>
<td>20</td>
</tr>
<tr>
<td>Sharing needles</td>
<td>38</td>
<td>54</td>
</tr>
<tr>
<td>Sexual intercourse</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>Saliva, body fluids, lack of cleanliness</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Blood</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Sharing injection equipment</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>

Note: More than one answer was allowed.

4.3 Research Objective #3

To describe clients’ perceptions of Street Outreach services.

4.3.1 Description of Respondents’ Perceptions of Street Outreach Services

To assess clients’ perceptions of services provided, service utilization data was used, including: reasons for using the needle exchange; types of services accessed; and changes made since using the program. Satisfaction with services provided from the mobile van, STD clinic and Hewgill’s Pharmacy were assessed as well.

a) Reasons for Using Needle Exchange

Respondents used the needle exchange service for five main reasons: i) assurance of getting clean needles (safety) (n=59/99); ii) convenience (n=44/99); iii) free needles (26/99); iv) caring and friendly staff (n=22/99); and because of other services provided (e.g., condoms, means to get rid of dirty needles, free disposal containers for dirty needles) (n=20/99).
b) Services from Van Used by Respondents

Respondents indicated which services they had received specifically from the mobile van. Table 4.19 summarizes their responses to this question.

The 'hard resources' such as needles and condoms are the services clients reported receiving most frequently. The 'soft resources' such as health information, referrals, or testing were not reported as often, but even these had been accessed by a third or more of respondents.

Table 4.19 Services and information accessed from the van

<table>
<thead>
<tr>
<th>Service/Information given</th>
<th>Number of respondents (%) ever having accessed services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needles</td>
<td>96 (99%)</td>
</tr>
<tr>
<td>Condoms</td>
<td>87 (90%)</td>
</tr>
<tr>
<td>Information about safe disposal of needles</td>
<td>65 (69%)</td>
</tr>
<tr>
<td>Information on getting HIV by sharing needles</td>
<td>45 (52%)</td>
</tr>
<tr>
<td>Information about hepatitis B and/or hepatitis C</td>
<td>44 (50%)</td>
</tr>
<tr>
<td>Information on getting HIV through sexual activity</td>
<td>42 (48%)</td>
</tr>
<tr>
<td>Testing for HIV</td>
<td>37 (42%)</td>
</tr>
<tr>
<td>Testing for hepatitis B and or C</td>
<td>35 (40%)</td>
</tr>
<tr>
<td>Referrals</td>
<td>31 (35%)</td>
</tr>
<tr>
<td>Immunization against hepatitis B</td>
<td>22 (28%)</td>
</tr>
</tbody>
</table>

Note: Total is greater than 100 because more than one answer was allowed.


c) Changes Made Since Using Service

Forty-five per cent (n=42) of respondents indicated that they had made changes in
their injecting practices since they began getting needles from Street Outreach, while 55\% (n=52) indicated they had not made any changes at all. For those who reported making changes, they related mostly to safer injection practices. For example, respondents mentioned not re-using needles or cleaning needles because they had more access to clean needles since being on the program, disposing of needles properly, and using alcohol swabs when they inject. Other changes included not sharing injection equipment, having needles on hand for others as well as themselves, and using condoms more. One respondent commented that he was able to “straighten out” his life because of the program.

d) What Respondents Liked Best and Least About the Service

Responses to the open-ended questions on what respondents liked best about the Street Outreach program were categorized into five different categories: attitudes of the staff, convenience or accessibility of the service, availability of free supplies, general satisfaction with the program or services provided, and safety reasons. Table 4.20 shows what clients reported liking best about the Street Outreach service.

Appendix I provides comments about Street Outreach staff made by the respondents. Most of the comments related to the staff being friendly, caring, non-judgmental and treating the clients with respect. One respondent commented, “they’re not in it for the money.”
Table 4.20  What respondents liked best about Street Outreach service

<table>
<thead>
<tr>
<th>What respondents liked best</th>
<th>% responding (N=100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff (caring, non-judgmental, friendly)</td>
<td>49</td>
</tr>
<tr>
<td>Convenient (accessible)</td>
<td>37</td>
</tr>
<tr>
<td>Free supplies</td>
<td>21</td>
</tr>
<tr>
<td>Good program or service</td>
<td>21</td>
</tr>
<tr>
<td>Safety issues (clean needles)</td>
<td>20</td>
</tr>
</tbody>
</table>

Note: More than one response could be given.

The majority of respondents (53%, 41/77) indicated that there was nothing they did not like about the service, while 24% (18/77) indicated that what they liked least about Street Outreach services had to do with inaccessibility of the service. In this case, inaccessibility related to the van not being around to provide needles, staff being too busy to respond quickly, or not being able to get through to the staff on the cellular phone when they needed to arrange for needle exchange. Only one respondent commented on the implications of being associated with a vehicle known for providing services to injection drug users. She responded that the “van represents a lot of stereotypes, like ‘junkies’ or ‘druggies’, ‘street person’– everything negative that people say about anybody who uses the van.”

e) Suggestions for Changes to Service

Thirteen per cent of respondents commented that there was nothing about the service that they would like to see changed, while seventy-two per cent offered suggestions for change. Changes for improvement to the Street Outreach service were separated into three categories which were confirmed by a second coder. The three
categories related to hours of service, services provided and service delivery methods. Table 4.21 illustrates the frequency of suggestions made by respondents within each of the three categories. Fifty-one per cent of those responding (n=43) suggested improvements to van hours which included extended hours of service. One respondent commented, “The drug scene doesn’t stop when the van is off the street.” Others suggested the van be out earlier, later, on Wednesday evenings, and 24 hours a day, seven days a week. Weekend services and daytime hours were suggested most frequently. Suggested hours ranged from as early as 1:00 p.m. to as late as 4:00 a.m. The most frequently suggested hours for the van were 6 p.m. until 2 a.m. There were more requests for earlier hours than for later hours.

Respondents suggested increasing services to include more vans, more locations for needle exchange, and more people providing service. One respondent commented, “sites should be closer to the neighbourhood.” At least two suggested needle vending machines or disposal depots in public places. Another respondent explained, “[there should be] a lot more of you, not enough time spent on the individual. I would like to spend more time with the workers.” A long-time client who participated in the survey added, “[the staff need to] sit and talk more to people.”
Table 4.21  Changes for mobile van services

<table>
<thead>
<tr>
<th>Suggestions for change</th>
<th>Frequency of responses (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hours of Service</strong></td>
<td></td>
</tr>
<tr>
<td>Weekends</td>
<td>(N=95) 20 (21%)</td>
</tr>
<tr>
<td>Earlier hours, including daytime hours</td>
<td>17 (18%)</td>
</tr>
<tr>
<td>24 hours a day</td>
<td>15 (16%)</td>
</tr>
<tr>
<td>7 day/week service (includes those requesting Wednesday night service)</td>
<td>13 (14%)</td>
</tr>
<tr>
<td>Earlier &amp; later hours</td>
<td>11 (12%)</td>
</tr>
<tr>
<td>Later hours</td>
<td>10 (10%)</td>
</tr>
<tr>
<td>Other (extended hours not specified, 5 or 6 days/week)</td>
<td>9 (9%)</td>
</tr>
<tr>
<td><strong>Services</strong></td>
<td>(N=32)</td>
</tr>
<tr>
<td>Services to include:</td>
<td></td>
</tr>
<tr>
<td>- raising awareness of services</td>
<td>7 (22%)</td>
</tr>
<tr>
<td>- others (smaller needles, incentives for disposal, babysitting, house calls)</td>
<td>7 (22%)</td>
</tr>
<tr>
<td>- sandwiches, drinks</td>
<td>6 (19%)</td>
</tr>
<tr>
<td>- birth control pills, tampons; vitamins, Vitamin E</td>
<td>5 (16%)</td>
</tr>
<tr>
<td>- spending more time with clients</td>
<td>5 (16%)</td>
</tr>
<tr>
<td>- taxi rides</td>
<td>2 (6%)</td>
</tr>
<tr>
<td><strong>Service Delivery Methods</strong></td>
<td>(N=22)</td>
</tr>
<tr>
<td>Other locations, easily accessible in neighbourhood; needle vending machines; disposal in public places;</td>
<td>12 (55%)</td>
</tr>
<tr>
<td>More vans; more people</td>
<td></td>
</tr>
<tr>
<td>Miscellaneous (address privacy in van, peer education, different vehicle)</td>
<td>7 (32%)</td>
</tr>
<tr>
<td></td>
<td>3 (14%)</td>
</tr>
</tbody>
</table>

Note: Respondents could choose as many answers as they wished.
Other suggestions for changes to improve the program related to increasing awareness of existing services so that all injection drug users in Saskatoon know about the program, as well as addressing the problems associated with used needles not being disposed of properly.

Some respondents who had reported that they did not want to see changes made offered suggestions for improvement in these three categories.

f) Satisfaction with Services from All Three Sites

Overall respondent satisfaction with services provided by the Street Outreach van was high. Satisfaction with the hours the van operates was lower in comparison to other variables, such as location, privacy, staff, educational information available, and the number and types of services offered. Satisfaction with the staff was the highest.

Thirty per cent of respondents had exchanged needles at the STD clinic at one time or another and rated their satisfaction with the services provided there. Again, the hours of operation were rated lower than location, privacy, staff, educational information, and the number and types of services available at the clinic. Respondents commented that the clinic should be open more hours, particularly in the morning, and many indicated that they do not use the clinic because they have to wait too long. There were respondents who were not aware they could exchange needles at the STD clinic. Respondents indicated the highest satisfaction with the number and types of services available at the clinic.

Twenty-seven per cent of respondents exchanged needles at Hewgill’s Pharmacy on 20th Street. They rated the educational information and privacy at Hewgill’s lower
than the location and hours for exchange. Satisfaction with staff was 'not bad.' Overall, satisfaction with Hewgill’s Pharmacy was lower than satisfaction with services from the van and STD clinic. One respondent commented that she only went to exchange needles at Hewgill’s once and never went back because she did not like their “nose up in the air attitude,” while another said they “make people feel ashamed.” Other respondents commented that paying customers get “preferred treatment” and that the staff do not say much about proper injection or disposal. Some complained that it is difficult to get new needles there because they will not give out a new needle unless the person has a used one to exchange, unlike the other locations.

Table 4.22 illustrates respondent satisfaction with services from all three sites. This variable was assessed by a Likert scale from 1 to 5, with 1 being ‘very poor’ and 5 being ‘really good.’

Table 4.22  Satisfaction with services by site

<table>
<thead>
<tr>
<th>Service</th>
<th>Mobile Van (Mean)</th>
<th>STD clinic (Mean)</th>
<th>Hewgill’s (Mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours</td>
<td>3.6</td>
<td>3.8</td>
<td>3.7</td>
</tr>
<tr>
<td>Location</td>
<td>4.3</td>
<td>4.1</td>
<td>4.3</td>
</tr>
<tr>
<td>Privacy</td>
<td>4.3</td>
<td>4.3</td>
<td>2.9</td>
</tr>
<tr>
<td>Staff</td>
<td>4.8</td>
<td>4.3</td>
<td>3.3</td>
</tr>
<tr>
<td>Educational information available</td>
<td>4.3</td>
<td>4.4</td>
<td>2.8</td>
</tr>
<tr>
<td>Number and types of services available</td>
<td>4.6</td>
<td>4.6</td>
<td>*</td>
</tr>
</tbody>
</table>

* Not assessed by survey.
g) Awareness

It is unclear whether the respondents are aware of all the services provided by Street Outreach (e.g., testing for HIV). One quarter of the respondents (n=25) were not aware that they could exchange needles at Hewgill's Pharmacy. Seventy per cent indicated they had heard about the Street Outreach program (needle exchange) from friends or relatives, while some (n=7) heard about it from "the girls working on the street," or from the program staff (n=11).

Appendix I provides other comments made by respondents regarding the Street Outreach program, the staff, and the survey in general.

4.4 Other Findings of Interest

When conducting any evaluation, unanticipated events might occur that have an impact on the program. While we were conducting interviews for the client survey, there were many unanticipated positive events. The evaluation process resulted in:

- more clients registering with the program;
- increased awareness of program services among clients;
- closer relationships between staff and clients;
- the opportunity for staff to clarify misconceptions with clients related to program services and health information.

When we were planning the procedure for data collection using the client survey, both the staff and myself had several concerns regarding the clients' participation. Although I wanted to interview 100 clients, neither the staff nor I thought that we would be able to do so given the nature of the questions we wanted to ask and the target group that we were interviewing. However, as in other cities (e.g., Calgary), there were
injection drug users who came forward to be registered with the program because they had heard about the evaluation and the incentive being offered for participating. It remains to be seen whether or not these people will continue to be clients; however, they did have the opportunity to meet with the staff and learn about the services. If nothing else, awareness of the service increased among a population at risk for HIV and other blood-borne pathogens.

As we prepared for the client surveys, the staff and I wondered about the clients’ reactions to the questions we were asking. Also of concern was whether or not the staff would have the time to conduct the interviews when they were busy. I am sure staff were concerned about interviewing clients given their other work demands. During the interview period, staff shared the following thoughts about the evaluation: i) they were surprised at how quickly the slower nights passed when they could do an interview or two; ii) they were surprised at the clients’ willingness and eagerness to participate in the survey; and iii) they enjoyed the level of client-staff interactions as a result of conducting the interviews as well as the new insights they gained.

Not only did the staff enjoy conducting the client interviews, but the clients appeared to enjoy being interviewed as well. Although I was unknown to many of the respondents, some expressed their enjoyment in participating to me as well. One of the respondents returned on a couple of occasions to talk with me about issues other than injecting drugs; others asked if they could come back again just to talk. Some respondents told the staff not to worry about the $20.00 incentive after they completed
the interview but all clients received the payment for participating. One respondent told me the money was a bonus and that she enjoyed talking with me.

Following an interview conducted in the van, a respondent disclosed that he was HIV-positive. He was known to the Street Outreach staff, but had never disclosed his HIV status until then. The staff person who interviewed him has had more contact with him since then and the relationship has grown.

We were concerned about the length of the interviews. In some cases they took 45 minutes to complete, particularly if clients were talkative. The length of time taken to complete the interview proved not to be problematic for any of the clients. Some of the interviews I conducted were in a tiny room at the STD clinic with only a table, two chairs, an old couch and a scale. Following several interviews done in this particular room, clients asked if they might weigh themselves. When they did, it seemed to open a new door for discussions about their injection drug use. After weighing himself, one young man told me he had lost about 17 pounds in the past year which he believed to be associated with injection drug use. Instead of leaving, he sat back down and started talking about his desire to quit injecting because of what it was doing to his body.

The other surprise arising from the surveys was the clients’ lack of concern about anonymity. Although we insisted on using client numbers and explained that there would be no identifiers or anything to link them to their answers, most clients introduced themselves by name and seemed totally at ease. I truly felt that the clients did not mind sharing information about this aspect of their lives and that they were interested only in telling their stories. We provided them with an opportunity to do so.
I attribute these positive unanticipated findings to the staff. They have been able to develop a trusting and respectful relationship with the clients. They make the clients feel comfortable enough to share intimate details of injection drug use and sexual practices with them. For these reasons, the staff are largely responsible for the findings described in this section.

4.5 Summary

The findings reported here have described aspects of service delivery, the nature of the clients using the Street Outreach needle exchange, and their perceptions of satisfaction with services, according to three research objectives.

a) Findings from Observations

Needle exchange is the largest activity and takes up the most staff time in the mobile van. It is more structured than condom distribution and usually involves distributing condoms as well as alcohol swabs and containers for dirty needles. Regardless of the reason for contact with clients, staff respond in the same open, friendly, respectful way. Although the length of time spent with clients is largely determined by the clients, that time may be cut short by other requests for service.

There is no consistency in the process by which new clients are registered with the program. Staff record transactions with individual clients on a statistical record according to their client numbers. Clients are usually unaware of their numbers and although they are told about them when they are registered, they are not encouraged to use them in their everyday transactions with the program staff. The staff look up the
number and record it on the statistical form.

Health information given to clients is usually done face-to-face and based on client need. Staff consistently remind clients to dispose of needles in the proper containers so they end up on the streets. Other information often centres around hepatitis B and C, HIV, birth control, pregnancy, and treatment of abscesses. The staff are in a good position to offer early intervention messages to this target group. An example would be teaching clients about vein maintenance to prevent abscesses.

Client referrals are spontaneous, based on client need. Follow-up is not consistent and difficult because of staffing and the nature of the target group. Testing and immunization were not observed during the observation period.

b) Findings from the Client Survey

The demographics of the 100 respondents attending the Street Outreach needle exchange were not surprising. More females than males responded. The mean age for clients was 29.5 years. About three quarters of the respondents indicated they were Aboriginal, a large number were unemployed and had a history of incarceration. All reported having a place to live and none reported having regular sexual partners of the same sex.

Many respondents reported having started to use needles by the age of 11. Almost all started using needles because their friends or partners introduced them to injection drugs. Multiple drugs are injected by this population, but prescription drugs appear to be the most popular and those used most regularly.

Unsafe injection practices such as sharing needles were reported by survey
respondents. Over half of the respondents reported using a needle that had been used by their partners or friends. Almost one quarter have done so within the past six months and two thirds of them did not always clean the needles before re-using them. Sixty-two per cent have shared injection equipment and almost half have done so within the past six months.

Injection practices are similar among respondents. Most inject every day of the week and every day of the month, indicating that the demand for clean needles is ongoing. Most respondents reported using injection drugs in groups of one to three people. Few inject with strangers, suggesting that ‘shooting galleries’ are not yet prevalent in Saskatoon. Respondents also reported getting needles for others, usually friends. The most frequent source of needles was through the mobile van.

New needles were accessible to most respondents (73%) because the van was around and they stocked up, or they knew of others who had needles. However, more than one quarter of respondents cited lack of accessibility to clean needles.

Sexual practices were risky in this cohort. Forty per cent of female respondents and 28% of male respondents had more than one sexual partner in the month preceding the questionnaire. Eight female respondents reported having had both female and male casual sexual partners, whereas none of the male respondents reported having same sex partners. Thirty respondents, all but one of whom were female, reported being paid for sex within the past six months, which likely explains why females reported having more sexual partners than did the male respondents.

Self-reported condom use with regular partners was low, while condom use for
to clients that same year. Both the number of needles distributed and the number of registered clients receiving needles increased from the previous year. The exchange rate for 1997 was 73%, ranging from as low as 57% to as high as 97% some months.

The number of condoms distributed by Street Outreach staff is difficult to track because of the way in which the information is currently being documented. Between 231 and 279 gross of condoms were documented as being distributed by staff, depending on the records reviewed.

In 1997, staff made over 500 client referrals. Follow-up is not documented. It is unclear where the majority of referrals were made because they were recorded as ‘other,’ suggesting a need for change in the statistical form. Other agencies to which clients were referred included medical clinics, STD clinic, and Native Addictions Council.

The number of clients screened for HIV, and hepatitis B and C and the number of immunizations against hepatitis B has been increasing each year in the target population. Records are not located in a central data base and are difficult to track.

There seems to be a good fit between the qualifications of staff providing the service and the nature of the clients receiving service. Although the intent of this evaluation was not to do a cost-benefit analysis, the costs for the Street Outreach project appear minimal for a project that offers potential savings in future health care costs related to HIV and hepatitis C infections.

It is evident from the findings that the Street Outreach program is highly regarded by the clients. The program success appears to be mostly attributable to the staff and street outreach method of service delivery.
5. DISCUSSION

This study was done to provide Public Health Services with baseline information about Street Outreach injection drug-using clients who used the needle exchange service, in addition to describing how the program operated. Baseline indicators were agreed upon with help from the management team as a means of describing the clients who were being reached by the program—their risks and knowledge of HIV, hepatitis B and C, and their satisfaction with services provided. Aspects of service delivery from the mobile van were described. One hundred clients participated in a face-to-face survey conducted by the program staff and myself. Program documents, administrative data, and the program database were used as additional sources of data in order to describe the process of the risk reduction component of the Street Outreach project.

The first section of this chapter discusses the findings related to the clients responding to the survey, services and client satisfaction, as well as issues related to service delivery. The next section presents limitations of the study, followed by a summary of recommendations for further research, and recommendations related to programming. A brief section on the collaborative approach to be taken in program delivery is followed by the conclusion.
5.1 Client Issues

The findings from this study demonstrated a need to continue the needle exchange service in Saskatoon. The major findings indicated that the injection drug users surveyed were at risk for HIV based on their demographics, risky injection and sexual practices. Their knowledge of HIV and hepatitis C was fairly high; however, this finding does not suggest that practices were consistent with that level of knowledge. Clients access the services provided and overall satisfaction with the program was high. Staff and delivery of service from the mobile van were valued most and rated highest by survey respondents compared to services provided at the STD clinic or Hewgill’s.

The findings also suggest a need for changes to be made in order to improve the service. These changes related to: services, service delivery, client referrals, and data collection and monitoring for on-going evaluation and program planning.

The following discussion considers each of the above findings.

5.1.1 Demographic Characteristics of Street Outreach Respondents and Program Reach

It is difficult to assess how representative our sample is of the total population because the data available on that population are not complete. The injection drug users in Saskatoon who responded to our client survey were similar in some respects to injection drug users elsewhere, but unique in others. As suggested in the literature, there is far more heterogeneity than homogeneity within this population than once believed.

Most of the Street Outreach respondents were Aboriginal and unemployed, with a
history of incarceration. While injection drug use is not associated with specific
economic or social boundaries, injection drug users frequently tend to be poor, socially
marginalized and stigmatized.\textsuperscript{62} In Saskatchewan, Aboriginal people tend also to be
socially marginalized, stigmatized, and poor. This may explain the higher number of
Aboriginal clients in the Street Outreach program. High rates of unemployment and
histories of incarceration are common in injection drug-using populations.\textsuperscript{71,72} One third
of the respondents supplement their incomes by selling sex for money.

The majority of respondents in this study were female, had fixed addresses, and
had at least a junior high school level of education. Women are often underrepresented
in needle exchange programs,\textsuperscript{4,55} but this does not appear to be the case in Saskatoon.
Unlike many clients from programs such as Vancouver or Toronto, injection drug users
who participated in this study have places to live. This finding is probably best explained
by the cold winters experienced in Saskatchewan. However, the large number of
Aboriginal clients may have also influenced the living arrangements in this cohort.
Extended families are not uncommon in First Nations people and they often share
accommodations, rather than live ‘on the streets.’ This sample may also be better
educated than attenders at other needle exchange programs,\textsuperscript{11} with the majority having
completed at least some level of high school. Post-secondary education was uncommon.

The majority of respondents were single or lived common-law. No one in our
study reported living with same-sex partners. This finding is unusual. Programs such as
\textit{Street Connections} in Winnipeg have high numbers of injection drug users with same-sex
partners,\textsuperscript{82} while other programs such as \textit{CUPS} in Calgary reported 6\% of their respondents with same-sex partners.\textsuperscript{79}

There are no age restrictions for clients being registered with the Street Outreach program, but the youngest client survey respondent was 15 years old. The literature suggests that needle exchange programs have historically attracted older injection drug users and this appears to be true in other Canadian centres as well,\textsuperscript{63} with the exception of Winnipeg, where clients have always tended to be younger.\textsuperscript{82} In our sample, 16\% of respondents were less than 20 years old, which suggests that the Street Outreach program may be reaching some groups not usually reached by these types of programs. However, there appears to be a problem reaching the very young injection drug users, especially since almost one third reported using needles before the age of 16 years and this age group was not reflected here. Data from the client statistical forms and observations show that the program does reach younger, street-oriented youth who access services from the mobile van. The number of needles issued goes up with client age.

There was a wide range in the length of time respondents reported using needles, from 4 months to 32 years. Four per cent had begun within the past year, approximately one half had used needles for one to five years, one quarter had used needles for six to ten years and another one quarter for ten years or more. This finding provides further support that the program attracts the more established injection drug users. Newer injection drug users may not be represented here because they are younger and more sporadic in their use, and perhaps not accessing the program like the older, more established injection drug users. Newer program users may have also been more
reluctant to participate in the survey.

Given the nature of the population under study and their involvement in illegal activity, we do not know how many injection drug users there are in Saskatoon now nor their age distribution. Further investigation into whether or not the program is reaching the younger injection drug users is warranted. Consideration should be given to developing intervention strategies that are appropriate with respect to cultural, gender, and age.

A discussion on program reach cannot be restricted to examining just those who access service. The program may also benefit indirect users—those who do not access services themselves, but who get new needles and other supplies via others. The secondary distribution rate of new needles seen in the findings, indicates that there are indirect program users who benefit from the Street Outreach needle exchange program without being registered with the program. While this makes it difficult to assess the number of injection drug users reached by the program, it is important that those who do not access the program for whatever reason, do have access to clean needles. For this reason, injection drug-using clients should be encouraged to take clean needles for others. This information could be tracked on the daily statistical form in order to get a sense of the secondary distribution rate among clients. Besides distributing clean needles to other injection drug users not registered with the program, it could be that those accessing needles and accurate health information from the program staff may also be disseminators of health messages as well.
5.1.2 Injection Practices

Multiple drug use in this cohort is evident. Morphine and ritalin are still the drugs of preference for the respondents in this study, although cocaine is a close third, with 32% using cocaine most and 40% using it on a regular basis in the six months preceding the survey. The preference for prescription drugs has implications for both injection practices and treatment. Morphine addicts are more likely to benefit from methadone treatment programs than those with cocaine addictions. Injecting morphine and ritalin means shooting up less often than injecting cocaine, thus fewer needles are required, and unlike cocaine users, there are no ‘binges’ (injecting several times a day for days and then stopping) with morphine or ritalin. However, it is important to realize that cocaine’s popularity could be increasing in Saskatoon, just as it has in larger centres like Vancouver. This would have tremendous impact on the number of needles needed by clients and may be one of the reasons for the increase in needles issued annually by Street Outreach now.

Frequency of injection depends on the types of drugs used as well as the level of drug use. Most of the clients inject several times a day, every day of the week and every day of the month. The number of times they inject in a day is influenced by the drug they are injecting. The types of drugs used depend on the market value and the availability of the drugs.

Over half of the respondents reported injecting five or fewer times per day, which is consistent with the use of morphine rather than cocaine. The data on frequency of injections also suggests that Street Outreach may not be reaching the more recreational
users, those who inject infrequently or those who inject steroids.

The social network appears to play a large role in the initiation into injection drug use. Almost three quarters of those responding indicated that they had begun to use needles because their friends or partners introduced them to it. Initiation into injection drugs for this group is likely similar to other groups, particularly for the younger injection drug users: curiosity, desire to join in, family environments, and peer influence. Further research is needed to examine the specific social networks surrounding initiation into injection drug using patterns and practices.

Respondents in our sample provided us with insight into the social context of their injection practices. They reported injecting when others were present, within a group context. However, injecting with strangers was not a common practice in this sample, which suggests that although people may congregate to shoot up, shooting galleries do not exist in Saskatoon.

One of the reasons injection drug users shoot up in groups may be for safety: In the event of an overdose, having someone else around could save a life. However, the literature suggests that injection drug users often inject with friends or relatives for pragmatic reasons (e.g., cost) and as part of a socialization process where habits, expectations and the means of survival are learned and shared within the group context. These factors may apply to this particular group as well.

*Risks associated with injection practices*

It is of concern that one quarter of the respondents have shared needles within the past six months and that two thirds of them did not always clean the needles before using
them. When needles were cleaned, the proper method was not always followed. This suggests that education is still needed about the risks of sharing needles and other injection equipment, as well as proper cleaning methods.

VanCaloen,\textsuperscript{41} in Montreal, has noted that clients share needles when motivated by craving or as an effect of the drugs, as well as voluntarily, or what he called ‘planned risk-taking,’ which involved sharing needles within the context of a trusting relationship. Other researchers have described needle sharing as a social-ritual behaviour where a social bonding is forged by sharing during an initiation into injection drug use.\textsuperscript{55,56} It is clear from these findings that some respondents will share a needle if it is the only one available, even if they know they should not. Sharing behaviour appears to be dictated by the availability of needles in the Street Outreach cohort, although social network cannot be overlooked because they share with friends and partners whom they see as loyal or ‘clean.’ The literature suggests that because of the social influences related to injection drug use, it is even more difficult for some injection drug users to insist on using new needles or at least cleaning them properly before re-using.\textsuperscript{41}

It is also clear from these findings that the majority of clients know not to share needles and will choose not to share if there are always new ones available. However, it is unclear whether or not some would still share with their regular partners even if new needles were always available. Examples of unsafe situations where clients thought they might share included: social situations (e.g., knowing their friends are ‘clean’), splitting drugs with partners, sharing needles when they needed a fix and there were no clean needles available, or when they were too ‘high’ from cocaine to know they were sharing.
This supports vanCaloen’s research and provides compelling evidence to flood the market with clean needles so that there is never a situation where they need to use a needle that has been used by someone else, even their partners. Unfortunately, this approach will not solve the problem of unsafe injection practices which occur as an effect of the drugs. Better solutions, such as changing group norms to foster safe injection, are needed.

Further research around the group dynamics of injecting, group norms around sharing equipment, and the social implications of not sharing are needed to shed light on needle sharing behaviours in our cohort and to help plan appropriate education programs. Social networks and social environments can effect the extent to which people engage in risk reduction and as such, have implications when planning prevention strategies. For example, if one knew what influence the group has on injection behaviours, education programs could be directed at changing group norms from risky behaviours to safe injection behaviours.

Although the majority of our respondents had not used needles when they were incarcerated, 16 had shared needles, few of which had been cleaned properly. Given the large number in this group with a history of incarceration and the inaccessibility to clean needles or appropriate cleaning agents in our provincial correctional institutions, the target group is put at even higher risk for HIV and hepatitis B and C. Even though many respondents felt it necessary to clean the needles before using them during their incarceration, they either lacked knowledge on proper cleaning methods or they lacked access to proper cleaning agents and used what they had available. Regardless of the
reason, they were put at increased risk for infection. These findings suggest the need for more education and access to clean needles and bleach, along with condoms, in our correctional institutions.

Sharing injection equipment is even more evident in this cohort than sharing needles. Sixty-two per cent reported having shared injection equipment and about half had done so within the past six months. Fear of HIV may deter some people from sharing needles, but risks for HIV and particularly hepatitis B and C from sharing equipment are not large deterrents, since this activity was not recognized by some clients as being risky. About one third of the respondents shared cotton or filters and over half, their spoons. Sharing injection equipment poses a substantial risk for hepatitis C and this practice likely explains the increased incidence of hepatitis C in the injection drug user population. This finding suggests that increased emphasis needs to be placed on educating about the risks associated with sharing injection equipment.

The use of other drugs, such as alcohol, has been explored in other evaluations because of the positive association with injection drug use. In our study, 72% indicated that they did not use alcohol on a regular basis. I have no explanation for the low use of alcohol in this cohort, except that approximately one quarter of clients who participated in the survey commented about being in treatment for alcohol at some time. If the treatment was successful, this may have contributed to the low use of alcohol.

Perceived risk for HIV infection

Over half (54%) of injection drug users responding to this questionnaire perceived their risk of HIV infection to be low. Even those who had shared needles or equipment
perceived their risk for HIV to be low. This finding is of concern, especially when injection practices include sharing needles and injection equipment. Of equal concern is their risk for hepatitis B and C, given their practice of sharing injection equipment.

Although over half of the respondents in our sample felt unlikely to be at risk for HIV, almost all had been tested at some time. This finding seems somewhat contradictory. Even those who had shared needles did not see themselves at high risk for being infected and yet most had been tested. From my own professional experience, I know that some people get tested every few months as a means of 'prevention.' They may or may not decrease their risk behaviours, but feel that early testing and knowing their HIV status is somehow a prevention strategy. The respondents in our sample may follow the same rationale regarding testing.

**Needle exchange practices**

Increasing needle exchange rates have been used as indicators of successful program implementation in some evaluations. However, when a one-to-one exchange policy (getting one clean needle for every dirty one returned) is not enforced, high return rates are difficult to achieve. It is of concern that the needle exchange rate for Street Outreach is only 73%, although this is considerably higher than the 48% reported in 1996. When needles are not returned, the risk of finding dirty needles in the community rises. Other needle exchange programs such as Edmonton, Calgary, and Winnipeg report 100% or greater exchange rates. The program in Calgary attributes the high rate to the involvement of other agencies (e.g., pharmacies) in needle exchange.

Public Health Services encourages people to call when they find dirty needles so
that they can be disposed of properly. Staff have begun documenting where needles are being found so they can pinpoint problem areas. Unfortunately, data on the number of dirty needles found prior to the initiation of the needle exchange were not kept. However, other evaluation studies,\textsuperscript{3,11,71} have not found needle exchange programs to increase the number of dirty needles in the community. Dirty needles in the community pose health risks and steps need to be taken to ensure proper disposal. Needle exchange programs have usually imposed a one-to-one exchange policy to encourage injection drug users to return their needles. While I do not advocate strict enforcement of a one-to-one exchange policy, clients need to be encouraged to return their dirty needles or know how to dispose of them in the proper containers.

Although the staff were consistent in delivering the message about disposing of their dirty needles properly and reminding clients that they did not want to see dirty needles ending up on the streets, not all clients took containers and it was unclear whether or not clients knew how to dispose of needles if they did not have the appropriate containers. One staff member said they had just begun suggesting that clients use tobacco or coffee tins as containers for the disposal of dirty needles. Clients need practical suggestions for disposing of their needles, and yet it is imperative that they do so safely, so as not to put the community at risk. One way of getting the message across to clients may be to specifically ask them how they plan to dispose of their dirty needles, especially if they do not take a container, and then offer suggestions for disposal which would be practical for them. Having several locations where clients could return their dirty needles would also be helpful.
5.1.3 Sexual practices

Risks for HIV and other STDs were measured by condom use and the number of sexual partners. There appear to be three very distinct groups regarding sexual practices: sex trade workers (who have both customers and regular partners), singles with regular and casual partners, and those who are married or living common-law with only one sexual partner. About one quarter of the female respondents and one third of the male respondents from our survey had only had one sexual partner in the past year, suggesting monogamous relationships for at least some of the respondents. However, almost three quarters of the female respondents and two thirds of the male respondents have had more than one sexual partner in the past year, putting them at higher risk for sexually transmitted infections, including HIV. One third of all respondents had been paid for sex within the past six months, all but one of whom was female, which likely accounts for the large number of women who reported having multiple sexual partners.

Vaginal sex with regular partners was reported by 85% of respondents and oral sex by 74% of respondents. Less than 10% reported having anal sex with casual partners and only 14% reported having anal sex with regular partners. The large number of respondents reporting vaginal intercourse, the number of females (71%) with more than one sexual partner in the past year, and the eight who have both male and female sexual partners, suggests that young women in this sample are at high risk for HIV if they do not use condoms consistently and continually. Younger clients, who have more sexual partners, are even more susceptible to becoming infected with HIV and transmitting the virus if they do not practice safer sex.
**Condom use**

Sixty per cent of all respondents did not use condoms with their regular partners in the six months preceding the survey. Condom use with casual partners was higher than with regular partners in our sample, congruent with the findings from Winnipeg’s needle exchange program. Only 7% reported not using condoms for vaginal sex with casual partners. Unfortunately, one quarter of those using condoms for vaginal sex with their casual partners did not always use them. Similar trends in condom use have been reported in other studies of injection drug users.

The number of respondents who reported using condoms for oral sex with their regular partners was surprisingly high: 32%, of whom 54% reported always doing so. Although undisputably a good practice, from my own professional experience in Sexual Health, it is uncommon for people to use condoms for oral sex, especially with regular partners. I have no explanations for the high numbers reported here.

Condom use among respondents who had been paid for sex within six months of the survey, was high for casual partners and not nearly as high for regular partners. Only one third used condoms for vaginal sex with their regular partners. If their sexual partners are also injection drug users or have multiple partners, they are putting themselves at greater risk for HIV. Further investigation into the determinants of condom use among sexually active injection drug users would be helpful in developing appropriate intervention strategies for those put at increased risk by dual behaviours of injection drug use and heterosexual intercourse.
5.1.4 Knowledge of HIV, Hepatitis B and C

While knowledge on the transmission of HIV was high, knowledge about strategies related to prevention of HIV was even higher. Even though almost everyone identified using condoms and not sharing needles as prevention strategies against HIV, there were still misconceptions that could be clarified by education. The risk of spreading HIV through vaginal intercourse was well known, while transmission via anal and oral intercourse was not as well understood. Less than half identified oral and anal sexual activity as ways of contracting HIV. Other specific details such as the risk of spreading HIV by sharing piercing or tattoo needles as well as sharing injection equipment was not mentioned by any of the respondents.

Respondents were more knowledgeable about the transmission of HIV than hepatitis B and C. However, they were more knowledgeable about hepatitis C than hepatitis B. This increased awareness may have resulted from the announcement of
monetary support by the federal government to the hepatitis C victims who contracted hepatitis C through ‘tainted’ blood transfusions. With the increasing number of people being diagnosed with hepatitis C, injection drug users may be infected with hepatitis C themselves or they may have friends who are infected and thus be more knowledgeable about it.

Some respondents were able to identify that sharing injection equipment posed an increased risk for hepatitis B and hepatitis C. Most were able to identify sharing needles as a risk activity for hepatitis C, but fewer did so for hepatitis B. Sharing body piercing or tattoo needles, as well as other injection equipment, were not mentioned by clients as means of hepatitis transmission, suggesting the same knowledge gap in the more specific means of viral transmission, as with HIV. The risk for hepatitis C is extremely high in injection drug users who share injection equipment and it appears that this message still needs to be given to the target group.

5.2 Service Issues

Clients in Saskatoon access needle exchange services at the van, STD clinic, and Hewgill’s Pharmacy. The degree to which the study sample is representative of the injection drug users accessing services at all three sites is unknown, as explained earlier, because of the lack of data collected on the total population. This information would have been helpful to confirm the representativeness of our sample. Some of the respondents accessed all three sites, while some only accessed one site, suggesting there could be very different types of clients. If client profiles were kept on registered clients, we might have
better insight into this issue.

Respondents offered five reasons for using the Street Outreach needle exchange. The assurance of getting clean needles was mentioned the most, by 60% of the sample. I was surprised that safety was listed as the most important issue for them. I remember seeing an interview with an injection drug user from Vancouver who was HIV-positive. He had knowingly used a needle that had been used by someone who was HIV-positive, because it was the only needle available. The journalist commented that this type of situation was not uncommon in Vancouver’s lower east side because of the hopelessness and uncaring attitudes of the injection drug users living in deplorable conditions. It is a strength in Saskatoon that this particular group does care about their safety. This concern should be used to improve knowledge and deter behaviours that put them at increased risk for HIV and other blood-borne infections.

Each year the number of clients exchanging needles and the number of needles exchanged with Street Outreach have increased. The literature indicates that needle exchange programs do not lead to an increase in the number of new injectors, so the increase in these numbers suggests, at least in part, that the program is becoming more successful in reaching injection drug users each year.

Awareness

It is difficult to truly assess awareness of the Street Outreach program because we did not interview injection drug users who were non-program-attenders. Given the size of Saskatoon and my experience with ‘word of mouth’ dissemination of information among this target population, I suspect that most of the injection drug users in living in
Saskatoon are aware of the needle exchange service. The extent to which they are aware of other services offered through the program appears limited. For example, one quarter of clients interviewed were unaware that they could exchange needles at Hewgill’s Pharmacy; some were unaware that they could exchange needles at the STD clinic. However, those who do not access needle exchange services likely have reasons other than lack of awareness. As indicated by survey respondents, people may not feel comfortable getting registered with the program, fearing involvement with the police, or being labelled ‘junkie’ by those providing service. As the program gains acceptance and trust with more and more injection drug-using clients, the number of registered clients will likely increase.

Although testing and immunizing services have been offered in the mobile van since needle exchange began, some clients were unaware of the service. This could be due to the fact that the previous nurse did not work as much in the van as does the current nurse. The number of clients being tested or screened and the number being immunized have increased each year. As awareness increases and staff encourage clients to be tested, even more are likely to be tested and immunized. With an improved database, the nurse would have better access to client records and a better system for knowing which clients are in need of testing or immunizing.

During the interviewing process, a number of clients commented on the staff providing service and not being paid. This surprised me. There also appears to be confusion between the PHS van and the Egadz van (a mobile van operated by a downtown youth centre which provides services to street youth), although neither is
operated by volunteers and the services are different. The Street Outreach staff are not perceived to be Public Health Services employees.

*Expansion of Services*

Survey respondents did not make a lot of suggestions for increased services. Some requested tampons, diapers, vitamins, and birth control pills. Other programs provide services based on client need. For example, in one of the programs in Toronto the needle exchange staff carry blankets and mitts for clients because a number of them are homeless. Saskatoon is fortunate. We do not have some of the problems that are prevalent in other cities, such as homelessness. In addition, other agencies such as Egadz also provide services to many of the same clients. It will be important to explore what clients expect and to work in collaboration with other agencies also providing service to the target group so that services are not duplicated.

Having a nurse in the Street Outreach program offers the flexibility needed to provide even more comprehensive services, which could include basic health assessments and treatment of abscesses, flu immunization and vein maintenance, in addition to general health information, and testing and immunizing services currently being provided. Expansion of nursing services would promote health and assist a hard-to-reach population to receive the health care they require. Potential client outcomes could include improved health, increased knowledge and skills, and increased access to the appropriate services.

Increasing the scope of nursing services and providing basic resources, such as tampons and vitamins may be sufficient for this particular population. A ‘best practice’
provision of services should reflect clients’ needs and the availability of resources.

An important aspect of providing comprehensive service is the provision of health information on safer injection and sexual practices in the target group. Almost one half of the survey respondents reported getting information on the risks of HIV transmission and information on hepatitis and another third reported getting information about testing services through the van. These findings suggest that there is an opportunity to teach this high risk group about many different health topics, including HIV prevention.

Other needle exchange programs have found the use of peer educators to be very helpful in disseminating this type of information.\textsuperscript{69,80,93} The program in Toronto hires former injection drug users for their peer education program with success. Vancouver’s \textit{DEYAS} also uses former street injection drug users as staff.\textsuperscript{69} Both programs find that peer educators are able to reach clients in ways that other staff have not.

During the interviewing process, one of the respondents commented that he no longer shared injection equipment and that he used alcohol swabs before and after he injects because the staff “nagged” him all the time about it. He said he finally gave up and did what they said because they were always ‘in his face about it.’ This finding suggests that Street Outreach staff may be able to influence behaviours simply by repeating important health messages.

\textit{Client Referrals}

It is difficult to assess whether or not client referrals are helpful to the program because of the way in which they are documented and entered into the database. While it is impressive that over 500 client referrals were made, it is difficult to assess whether or
not clients have accepted, followed through, or benefited from them. The statistical form
does not adequately provide information about where clients are being referred. As
mentioned earlier, there is no mechanism in place to deal with follow-up for clients who
have been referred; that is, whether or not the referral was acted upon. The flexible hours
kept by the outreach workers, a lack of documentation, and the nature of the clientele
prevent consistent client referral follow-up.

Since client referral networks have been listed as one of the three ways in which
to provide broad-based services to the target population and are supported in the literature
as valuable to needle exchange programs, referrals should be examined more closely.
The opportunity for collaboration and partnerships with other community agencies also
providing services to the target group is extensive.

5.2.1 Satisfaction with Services

It is clear from the survey responses, observational data, and comments from
clients that the relationship between the staff and clients is one of the program strengths
and plays a large part in its success. The staff are valued by the clients because of their
friendly, caring, respectful and non-judgmental attitudes. Clients feel valued and
accepted for who they are, and not looked down upon for their way of life. A successful
needle exchange program is one that is user-friendly, where clients have developed a
trusting relationship with the staff. In this regard, the most valuable Street Outreach
program resource is the staff and what the survey respondents indicated they liked the
best about the Street Outreach program.
Suggestions for improvement to Street Outreach service related to hours of service, services provided and service delivery methods. These changes should be examined further and considered. While the majority of clients suggested extended hours, the hours suggested most frequently were weekend and daytime hours. The van used to go out on Saturday evenings, but stopped doing so a few years ago when staff noticed that the number of contacts being made was considerably less than other nights. Responses suggesting more daytime hours are somewhat contradictory according to data collected on the daily client statistical forms, which indicated the majority of contacts with the van were after 9:00 p.m. This finding may be explained by the two different types of clients: Those who plan ahead and arrange for service early and those who are more spontaneous in their need for services and do not access services until later.

Some respondents commented that the van should be out on Wednesday evenings. Prior to June, 1997 the van was out on Wednesday evenings, but now it goes out from 2:00 p.m. to 6:00 p.m. on Wednesdays. The change to Wednesday afternoons from Wednesday evenings was made to give the staff the opportunity to connect with other agencies who also worked with Street Outreach clients. According to the client statistical data, when the van began service on Wednesday afternoons, there was little change in the number of contacts made. Gradually, however, the number of contacts made on Wednesdays has decreased, especially the number of needle exchanges being done. This finding may be due to seasonal effects and should be examined with that in mind. Extension of hours and being out Wednesday evenings could increase access for those who saw inaccessibility as a problem.
Satisfaction with services at all three sites

Overall, satisfaction with the STD clinic and mobile van was high. Hewgill’s Pharmacy as a site was not rated as high as the STD clinic or the van, except for satisfaction with location. Clearly the staff and convenience of accessing services from the van are important reasons for the van being rated as highly as it was. Dissatisfaction with the hours that the van operates were voiced and suggestions included extending hours as discussed earlier. The same pattern of dissatisfaction with hours of service emerged for both the STD clinic and Hewgill’s. Other issues at Hewgill’s that were not issues at the STD clinic or the van were dissatisfaction with the staff, lack of privacy and the lack of educational information. This finding suggests that the program staff as well as the STD clinic staff are sensitive to the issues surrounding injection drug use and the harm reduction approach to providing service. Providing information on disease prevention and health promotion is an important aspect of both clinic and van services. Respondents appear to value this service and commented on the lack of the same service at Hewgill’s. Clients should always have access to information on the proper disposal of dirty needles and the importance of not sharing needles or other injection equipment. The need for other health or educational information at all locations will require further examination.

Although the methadone program is not associated with the Street Outreach program and is beyond the scope of this evaluation, clients had so many comments about the program I feel compelled to include them. Seventeen respondents were on the methadone maintenance program and all of them spoke about the positive changes they
had made to their lives since being on the program. Most comments centred around feeling in control for the first time since their drug use began. The methadone program should be encouraged as a possible way of empowering injection drug users in Saskatoon and as a means of providing them with an alternative to injecting drugs.

5.3 Service Delivery Issues

Another factor contributing to program success is the street outreach service delivery in the community. Clients have access to clean needles from the mobile van and the majority of clients have accessed services from the van. Services from the STD clinic are similar to those provided from the van; however, some clients do not use the STD clinic because they have to wait in turn to be seen by a nurse. If the clinic is busy, they may have to wait a long time to be seen. If the wait is too long, they leave.

Given that about one third of respondents have accessed needles from the STD clinic, consideration will need to be given to this issue if PHS relocates as planned. As a location for needle exchange, the clinic was rated almost as high as the van and Hewgill’s. Although there might be different clients accessing services at the STD clinic, I suspect it is also used as an alternative site when the van is not around in the afternoons. As such, it will be important to plan for needle exchange if PHS moves from the existing site.

Although most of the respondents did not find it difficult to get new needles, over one quarter said they had difficulty accessing services. The reason for these seemingly contradictory responses might be related to the two very different types of clients: The
more regular injection drug users who can plan ahead, and those who are more spontaneous in their injection practices and do not plan ahead. The latter likely find it more difficult to access needles and are more likely at increased risk for sharing needles.

Half of the respondents reported injecting every day of the week and every day of the month, which suggests the need for access to clean needles seven days a week. Inaccessibility for one quarter of the Street Outreach clients may be solved by the addition of several neighbourhood locations where needle exchange is provided. Pharmacies, public health and medi-clinics, and hospital emergency departments are examples of different agencies that could be involved. Collaboration with several different pharmacies and clinics will likely require involvement by the Medical Health Officer or provincial bodies of medical health officers to emphasize the public health approach to this type of intervention. Education around a harm reduction and public health approach to needle exchange should accompany the request for other agencies to get involved. Clients must always feel that they can access needles without being hassled or judged. Respect for privacy and client confidentiality, in addition to the principles of harm reduction, are essential for the agencies and their staff to understand before becoming a designated needle exchange site. Staff at the other locations will need instruction on working with these clients and should have that type of information and understanding before they begin to serve these clients.

Multiple locations for needle exchange should also help to get dirty needles off the streets. Involving the city park, recreation and fire departments and other agencies such as local pharmacies have been successful in helping other programs\textsuperscript{91,71} in getting
needles back and would likely do the same here. However, everyone's involvement will be needed, from the MHO and program supervisor, staff, to clients, other agencies, and the community. Providing clients with several different locations to exchange needles, and appropriate disposal containers, along with health messages that discourage sharing, will promote the program and enable clients to take responsibility for their own dirty needles and at the same time, increase access to clean needles. This issue is a public health issue and it requires leadership within the public health mandate to address the problem and find solutions. However, it is also too large and complex an issue to be undertaken by one agency alone and will require collaboration with other community partners.

Data Collection on Service Delivery

Adequate and up-to-date client data are valuable for on-going evaluation of services and service delivery. Having appropriate data collection instruments for gathering this type of information would be helpful to the staff. The client daily statistical form currently used for the purpose of collecting data on clients is not adequate. The previous form was small and difficult to enter data. Recently the sheet was enlarged, but little thought went into assessing the type of information needing to be tracked for ongoing evaluation purposes. Improvement of the form will likely help to improve the accuracy of the data being collected. Some of the discrepancies (e.g., number of needles issued compared to the number from the inventory record) may have resulted from recording data on the previous form. Careful reflection on the data needed in order to provide management with necessary information for program planning is
essential.

Re-designing the computer database used in this program is paramount. The database is not easily accessible to management or program staff. It is unfortunate that the potential for such valuable information is not being utilized and has not been used to help in program monitoring and planning for the past five years.

*Policy and Procedures Guiding Service Delivery*

The policies with respect to the Street Outreach project are outdated. Inconsistencies of practice in the policy and procedures centred around needle exchange with clients, the registration process, and the recording of data which is kept for statistical purposes. It is difficult to assess who the 'active' clients are because of the way in which records are kept.

Needle exchange with new clients is inconsistent and does not reflect what is in the policy manual. There is no standardized procedure for staff registering new clients in the program. Valuable information about potential risks could be collected on clients in order to direct program planning, but it is not being done. Historically, the staff were reluctant to ask clients too many questions and important information has been lost as a result. Given the trust that has developed between clients and staff, this situation may no longer pose a problem for the staff in collecting data for program accountability.

*Program Resources*

Street Outreach staff are liked and respected by the clients. It is obvious that over the past five years, they have gained the trust of the clients with whom they work. Staff are in a good position to continue that relationship and improve services to the targeted
group while doing so in an economical way. Management wanted staff that could work as part of a team to deliver services to a hard-to-reach population and it appears as though they have done just that. The Street Outreach program costs less than $130,000 per year to operate. PHS receives $66,000 for Street Outreach from the province with the expectation that $44,000 is to be spent on needle exchange. Given that the direct medical costs of one HIV infection are in excess of $100,000, the Street Outreach needle exchange program need only prevent one HIV infection a year and the program would more than pay for itself.

In order to continue providing quality service based on a trusting relationship between the staff and the target population, the staff need time to ‘connect’ with the clients. They need to be able to follow-up with client referrals and to provide health information or counselling along with ‘hard’ resources (needles and condoms). They also need time to just sit and talk with clients. To do so may require an increase in staff hours. Clear guidelines regarding provision of the ‘softer’ resources (client referrals and follow-up) need to be developed. There should be a review of the time staff spend in the office. As discussed earlier, the part-time outreach workers are scheduled for daytime hours, but they often flex their hours so may not be at work when they are scheduled. While this type of arrangement may be popular with the outreach workers, it may be more advantageous to the program to work within the scheduled hours. Staff may find that doing so would increase their ability to provide client follow-up and make it easier to discuss and plan specific client interventions with each other. Extending staff hours in the van may be sufficient to provide more time for connecting and client follow-up.
Following the development of guidelines for client referrals and review of staff time spent in the office, re-examination of staff time needed to develop and maintain the connecting client-staff relationships is warranted.

5.4 Limitations of the Study

The client survey component of this evaluation had several limitations, largely due to the nature of the population and environment being studied. Other evaluations of needle exchange programs and research on injection drug users have been limited in many of the same ways.

The sample for the client survey was a convenience sample and included only those injection drug users who used the Street Outreach needle exchange service. Neither a randomized sample nor a comparison of non-program participants was possible because of the hidden and illegal nature of the injection drug user population, as well as the confusion in program documents with regards to client registration and attrition. The sample size was limited by the time and money available to conduct the evaluation; however, it was adequate for the purpose of this study.

Data on the total population was not available because of the limited information gathered by the staff on program clients. For this reason, it is difficult to assess how representative the sample is of the total population.

The data obtained from the client survey were based on self-reports. Injection drug users may have fabricated, exaggerated, or minimized their sexual and injection risks. There are no appropriate means of verifying the behaviours reported on the survey.
Response and recall biases were possible given the nature of the questions, the action of psychoactive drugs on memory, and the illicit nature of injection drug use.

Although data were utilized from a variety of sources for this evaluation, some data were unable to be used. Assessing convergence or divergence with other data sources (e.g., client statistical data) was hindered by the questionable accuracy of that data, resulting from the poor quality of the data collection instrument currently used by the program staff and lack of data on the total population.

Interviewer bias was a limitation in this study. The program staff and I administered the client survey. The clients may have been reluctant to voice dissatisfaction with program staff or the service when asked the questions relating to satisfaction in the survey.

Limitations related to observations included the possibility that, as the observer, I may have affected the staff and clients in ways that were unknown. In turn, this could have affected the data I collected. Another limitation related to observations was the focus on external behaviours. Observational techniques cannot ascertain what is happening inside people that might better explain the external behaviour being observed. Observations in this study were constrained by time as well.

This evaluation provided process information only for the risk reduction component of the Street Outreach program. It did not evaluate the street outreach/advocacy or public education aspects of the program, nor did it evaluate the time program staff spent in the office. In order to evaluate the program in its entirety, these components should be examined. Specific nursing activities such as testing and
immunizing were not included here because I did not have the opportunity to observe them during the data collection period. Further, I did not observe the staff working together as a team when they provided service from the mobile van.

Another limitation related to the conceptual framework used in this particular study. Dwyer's Program Logic Model, like other program logic models, does not account for extraneous variables influencing the indicators being measured. For example, during the time observations were being conducted in the mobile van, the police were 'cracking down' on the sex trade workers and some evenings there were only a few out working. Because sex trade workers make up about one third of the Street Outreach clientele, this may have affected my observational data.

5.5 Summary of Questions for Further Research

Questions arising from this study include:

1. Is the Street Outreach program reaching the younger injection drug users?

2. What are the specific social networks surrounding initiation into injection drug using patterns and practices?

3. What is the group context of injection drug use in this population, and what are the group norms around sharing equipment, and the social implications of not sharing? Investigation would shed light on needle-sharing behaviours and be helpful in planning appropriate education programs.

4. In which situations would clients share needles? Examination of the length of time respondents are in the program as it affects their needle-sharing behaviours was not
done in this evaluation study and would be interesting to explore.

5. *What are the determinants of condom use among sexually active injection drug users?*

6. *What community resources are used by injection drug users? What community resources are perceived as being helpful?*

7. *What factors support recovery from injection drug use?*

8. *How prevalent is secondary distribution of needles? How does secondary distribution affect program use and injection practices?*

Related areas for research include the effects of the following on injection drug users: employment and income issues, housing, incarceration, sexual abuse, prostitution, addiction treatment, alcohol addiction, nutrition, and health services utilization.

Future evaluation studies include:

i) Process information on the two other program components (client advocacy/counselling and public education). Evaluation of the public education component could be completed easily in the future along with other public education activities offered by PHS.

ii) An outcome evaluation following the development of client and program outcome indicators. An HIV seroprevalence study may be part of an outcome evaluation, as it has in many of the other needle exchange program evaluations, but program effectiveness should not be judged by this type of study alone.
5.6 **Recommendations for Programming**

Based on the findings from this process evaluation it is recommended that PHS:

1. **Re-design the data collection tool and the Street Outreach computer database.**  
   I suggest using ‘Guidelines on monitoring HIV prevention programs for drug users’, published by the Canadian Public Health Association in *Canadian AIDS News, Vol. IX, Number 4 Spring 1997*. The database should include linkages to client profile risk files, and testing and immunization records, so that the staff have updated information about their clients. Data entry and data analysis should be timely to provide management and staff with information necessary to make decisions related to programming.

2. **Establish community partnerships to provide more needle exchange locations, ensuring increased accessibility to clean needles for all clients.**  
   These new partners should have close ties to the program and the harm reduction philosophy. Partners to consider include pharmacies, medi Clinics, and hospital emergency wards within one kilometre of where injection drug users live. Provide instruction to the new partners around the harm reduction and public health approach to prevention, in addition to developing the sensitivity required to work with the target population. This intervention could eliminate the need for extra staff time and providing services by van on weekends and during the day.

3. **In collaboration with city departments (e.g., parks and recreation), public health departments (e.g., Safe Communities) and clients, explore ways to get dirty needles off the streets.**
Examples include mail box drop-off boxes in the community, providing all clients with appropriate disposal containers and encouraging everyone to take responsibility for returning or disposing of their dirty needles properly. As suggested by Canada’s National Task Force on HIV, AIDS and Injection Drug Use, pharmacies should be the focus of needle disposal because they are usually found in communities, open long hours, and sell needles. This issue should be addressed as a health and safety issue requiring an interdisciplinary approach.

4. Extend mobile van services to include:
   - resuming Wednesday evening service delivery (eliminating Wednesday afternoons), and
   - delivering services from 7:00 p.m. to 1:00 a.m.

5. Re-evaluate changes made in program delivery after three to six months to assess increased accessibility.

6. Expand nursing services to include:
   - provision of materials for simple dressings, treatment of abscesses, or other minor wounds;
   - flu vaccinations;
   - provision of vitamins;
   - TB screening; and,
   - closer collaboration with physicians in the community to enhance and facilitate access to appropriate medical care.

7. Review the time spent by program staff during daytime office hours.
8. *Increase public relations about the Street Outreach program.*

Needle exchange is an essential and effective component of HIV prevention.² PHS should review the recommendations put forth by the Task Force on HIV, AIDS and Injection Drug Use to ensure that as an agency they are doing what they can to address the problem of HIV in the injection drug population in Saskatoon. As suggested by the task force, agencies like PHS need to lobby for an intersectoral response at all government levels based on emerging evidence of the epidemiological data² regarding the intersecting issue of HIV and injection drug use. This is a health and social issue, not a criminal one!

9. *Staff should provide education which emphasizes:*

- safer sex, because of the large number of clients who are at risk of HIV through heterosexual sex;
- safe injection practices, including the message not to share injection equipment;
- proper disposal of dirty needles;
- proper cleaning method for dirty needles; and
- vein maintenance.

In addition to needles and containers, consider developing simple printed resources to give to clients that illustrate prevention strategies by pictures. Explore the possibility of hiring peer educators to help disseminate information to increase knowledge of HIV risk related behaviours to the target group. Grants from Saskatoon District Health may be one way of funding such an initiative.
10. *Increase awareness among clients, other agencies and the public regarding services offered through Street Outreach.*

Clients should be kept informed about services available and any changes regarding those services. Providing a newsletter three or four times a year might be a good way of passing on simple health messages and other program news to program users.

Staff should promote testing and immunizing services on a routine basis for clients. Updated computerized records would help the Street Outreach nurse and workers to know who needs to be re-tested or immunized. Provision of testing services also provides the nurse with the opportunity to do more face-to-face educating about prevention strategies.

PHS should put more emphasis on public education to raise awareness about the comprehensive services being offered by the program.

11. *Develop a client referral process which includes follow-up.*

There should be collaboration between program staff and other agencies working with the target group (e.g., a closer working partnership with Addiction Services) to facilitate client referrals. The referral process should include follow-up and appropriate documentation for evaluation purposes.

12. *Develop a standardized registration process for new clients.*

Clients should know their numbers and be encouraged to use them. The policy and procedure manual should be revised to reflect accurately delivery of service and client registration.
13. Explore ways of enhancing culturally and gender-appropriate interventions when dealing with this population where the majority are Aboriginal and women. For example, PHS should hire Aboriginal and female staff when possible, consult cultural/spiritual representatives to address the problems of HIV and injection drug use in the Aboriginal community, and plan culturally and gender-appropriate prevention strategies.

14. Explore with staff and clients where to locate a fixed site if PHS moves from the existing Idylwyld office.

The site should offer comprehensive services, not just needle exchange, in order to achieve decentralization and integration with a broader range of health services. Clients accessing needles from this site (and currently the STD clinic) should be seen quickly and should not have to wait in line to get clean needles.

15. Improve working conditions in the van by making necessary repairs and improvements to the van.

16. Explore ways of reaching very young injection drug users in order to intervene early.

17. Support:

• the methadone program and the need for more physicians to be trained to offer this type of treatment; and

• changes within provincial and federal corrections so that injection drug users have access to clean needles, bleach, and condoms when incarcerated.
18. In collaboration with other agencies providing services to this target group, explore the feasibility of providing supplies not being offered. These may include such supplies as sterile water, tampons, sanitary pads, diapers, band-aids, vitamins, contraception, and cough drops.

5.7 Collaboration

A collaborative model for HIV prevention in Saskatoon requires multi-sectoral partnerships. Partnerships of community agencies who take shared responsibility for HIV prevention in this city are essential. Partners could include: Saskatoon District Health divisions such as Addiction and Mental Health Services, treatment centres (Larson House, Calder Centre), and pharmacies, City of Saskatoon (parks and recreation, waste management, police, fire), Social Services, provincial corrections, Aboriginal organizations, AIDS Saskatoon, and Street Outreach clients. Some of these stakeholders comprised an advisory committee when the program initiated but the committee disbanded due to the lack of a clear mandate and functional guidelines. Despite the challenge in operationalizing this type of collaborative approach, it has worked with success in Edmonton. The National Task Force on HIV, AIDS and Injection Drug Use suggested that a similar approach be used to address this complex issue.

Benefits from a collaborative approach to HIV prevention include:

- providing choices, being responsive, and ensuring broad access to the target population;
- creating community partnerships;
- creative problem solving among the key players;
- coordination of services and shared planning with the target group;
- increased likelihood of reaching the target population;
• stronger case for funding and pooling of resources;
• increased legitimising of the program in the community; and
• utilization of several sites and approaches to reach the target group.  

A harm reduction approach to HIV prevention means giving people the opportunity to change their own behaviour by making it easier for them to make changes in stages and by offering them options. Needle exchange programs are important components of a harm reduction approach to injection drug use. But needle exchange and access to clean needles are not enough, they are only the first step. The next step requires changing attitudes about the issue so that the necessary community partners can work together to offer better solutions to the problem. Injection drug users do not live on an island. They live in our communities, they have partners and they have children. Their lives touch many others, affecting and infecting people who have never used drugs. Effective strategies have been used to teach injection drug users safer methods of injection which can protect them, their partners and their children from HIV. In many cases these users have been given enough support to stop using injection drugs. As the medical health officer for the lower east side of Vancouver commented, "What injection drug users need is something to eat, a place to live, and someone to give a damn!" Injection drug users are not 'junkies.' They are human beings who use drugs.

The national trend towards an increasing number of injection drug users becoming infected with HIV suggests that without adequate and appropriate interventions, Saskatoon's injection drug-using population could follow the same pattern of increased HIV incidence. The challenge for PHS will be to take a leadership role in this area. Getting support for this type of program will be a 'hard sell.' It is not a 'nice'
project such as raising money for underprivileged or disabled children. There is ample data, however, to support the need for the needle exchange program and a harm reduction, public health approach to the problem. Injection drug use in Saskatoon is a health problem and it will require PHS working with community partnerships to provide solutions.

5.8 Conclusion

The initial pilot proposal for the Street Outreach project recognized the need to provide a broad-based program through a cooperative effort of community services: street outreach, client referral network, and needle exchange. These were identified as the approaches needed to reach the target population of street-oriented youth, sex trade workers, injection drug users and their sexual partners. Activities to meet the Street Outreach goals and objectives rely upon the provision of risk reduction materials, client advocacy/counselling, and public education.

The findings indicate that the Street Outreach program is providing needle exchange, condoms, health information, client referrals, and testing/immunizing services specified in the process objectives outlined in Figure 1.2 for the risk reduction component of Street Outreach. The degree to which each activity or process objective is being met has been discussed in the preceding sections according to the process indicators for each.

A description of services provided from the mobile van and clients’ perceptions of Street Outreach services was presented in the preceding sections and the program’s strengths and weaknesses pointed out.
Weaknesses in the Street Outreach program have been identified and include: perceived inaccessibility of clean needles for one quarter of the clients; lack of collaboration with other agencies, programs, and medical personnel who also work with the targeted population; lack of community cooperation and collaboration with city departments, other public health departments and pharmacies to improve proper disposal of dirty needles; lack of awareness by clients and the public regarding Street Outreach services; inadequate client referrals and follow-up; inadequate data collection tools, data base and analysis of program data; lack of consistency with regards to client registration; and limited services being provided to clients.

It is clear from the findings that the major strengths of the Street Outreach program are the staff and the street outreach service delivery method. The staff have been able to develop a trusting relationship with the target population of sex trade workers and injection drug users, with a somewhat more limited relationship with street-oriented youth. Clients are willing to talk to the staff, thus obtaining the support they need not only to change risky behaviours, but also to make lifestyle changes. Because the relationship is one of respect and ‘connectedness,’ the staff are appropriate and have been able to reach this otherwise ‘hard-to-reach’ population.

The favourable working relationship between the staff and the clients provides opportunities to intervene early into medical problems associated with injection drug use in this target population. There is opportunity for prevention messages regarding HIV, and hepatitis B and C, and other STDs to be relayed to an at-risk group. Having a nurse working in the van allows for more flexibility in the types of services being offered and
provides delivery of more comprehensive services.

Offering services in the community from the mobile van has provided access to clean needles for the majority of Street Outreach clients. Convenience of service has resulted in at least one third of the clients accessing all of the services provided from the van.

Other program strengths relate to the clients reached by the program. This program has been able to reach established injection drug users, some younger injection drug users, females, and those working in the sex trade, in addition to a large number of Aboriginal clients who may have been further marginalized by their injection drug use. The clients’ concern for safety regarding clean needles is also a strength and has implications for programming.

A review of the resources shown at the bottom of the conceptual framework for this study as seen in Figure 1.2, suggests that the staff possess the necessary qualifications for the job and the number of staff appears adequate for program delivery. I have recommended increasing the amount of staff time in the van to promote more connecting with clients. In order to do so, it may be necessary to increase staffing hours to accommodate the increase in service. Following clarification of what is needed regarding client follow-up and a review of staff activities during daytime hours, further examination of the staff time required is recommended. Increasing hours for the staff naturally assumes increases in program funding. Other suggestions for dressing supplies, tampons, and vaccine for flu immunizations will also increase the need for extra funding, but the increase should not be substantial.
Finally, the Street Outreach program offers a knowledge-means approach to prevention, based on the provision of education and the means to effect change. The program appears to do so economically. Street Outreach has taken the first step in providing needles, but distributing needles alone is not enough, as shown by the findings from some of the larger centres like Vancouver. Other aspects of the service must be enhanced to improve the quality of services being provided. These intervention strategies require support from middle and senior management levels of PHS. In turn, PHS will need support from other agencies in Saskatoon to take on a leadership role in this area.

In conclusion, Street Outreach is providing a quality service to a very high-risk population. The findings from the process evaluation suggest that by expanding service delivery methods and the services offered, there could be even more health benefits to the injection drug users, their partners, and the community at large in Saskatoon. This evaluation provides baseline indicators for comparison in further impact and outcome evaluations.
References

17. Dwyer J. Applying program logic model in program planning and evaluation. PHERO February 1996.


Appendix A
Glossary
**Backloading:** Refers to transferring the drug from one syringe to the next by removing the plunger of the receiving syringes.

**Booting:** Occurs after registering and administering of drug solution; the drug user pulls back on the plunger to fill the barrel with blood and then reinjects the blood once or more.

**Cooker:** A small container, usually a spoon or metal bottle cap in which a drug in powder form is mixed with water and heated into a solution.

**Cotton or filters:** Cotton balls or cigarette filters that are placed in the cooker; injectors draw up the drug solution through the filter in order to filter out the particulate matter.

Fixing or cranking: Injecting, usually referring to illicit drugs.

**Direct needle sharing:** The reuse of needles and syringes that have been contaminated through prior use by another person, who may or may not be infected with a blood-borne pathogen.

**Efficient mixing:** When injection drug users mix with other injection drug users, the risk of transmitting any of the blood-borne pathogens is more effective because the risks of becoming infected are higher.

**Gear:** Any injection drug equipment (e.g., cotton, filters, spoons).

**IDU:** Injection drug user.

**Indirect needle sharing:** Common usage of other drug preparation or injection equipment that can be contaminated and facilitate the transmission of blood-borne pathogens, particularly hepatitis C.
NEP: Needle exchange program.

One-for-one exchange: A new syringe is given for one used syringe returned.

Quota: Maximum number of syringes that can be exchanged per visit or per unit of time.

Registering: Once a needle is inserted, the drug user draws back the plunger of the syringe to look for blood to ensure proper placement in the vein.

Rig: Often referred to as any type of syringe or ‘point’, but many refer to needles and syringes that have been filled with drugs, ‘rigged’ or ready to use.

Rinse water: Containers of water used by one injector to draw up and squirt out tap water between the use of needles and syringes by other individuals. Contamination increases with greater use and is commonly shared for the mixing of the drug solution to be injected. Sharing rinse water poses the greatest threat for HIV transmission, especially when cocaine is being injected (cocaine is water soluable and does not require heating in a cooker to be dissolved).

Shooting gallery: A clandestine location where injection drug users go to rent needles and syringes, and fix.

Speedballs: Refers to a mixture of cocaine and heroine used to inject.

Track marks: Visibly scarred veins as a result of injecting repeatedly.36
Consent For Observations of Service Delivery in the Van

Maureen Laurie is conducting a process evaluation of the Street Outreach needle exchange service from February to April 1998. The evaluation will i) describe the Street Outreach needle exchange clients who are injection drug users (or have been within the last 6 months) and their risks for HIV, other blood-borne pathogens and sexually transmitted diseases; ii) describe clients' perceptions of Street Outreach; and, iii) describe some aspects of service delivery, focussing on service provided from the mobile van. To meet the third objective, Maureen needs to accompany the staff when they provide services in the van. Observing staff will give Maureen first-hand knowledge of program operations so that she can accurately describe service delivery.

Arrangements will be made with the program supervisor if permission is granted. Suitable opportunities will be negotiated to least disrupt normal service delivery. One option is to allow Maureen to drive the van. This would least likely interfere with clients since they usually interact with the nurse or outreach worker sitting in the passenger seat. She will be introduced to the clients as a researcher, observing staff providing services to them for research purposes.

The Street Outreach staff will be informed of the dates in advance when Maureen will be observing. Street Outreach staff may ask Maureen to discontinue her observations at any particular time, if they wish. Doing so will not affect their status with the program. Possible benefits to Street Outreach staff as a result of the observations include potential changes made to service delivery which may improve their working conditions; however, no benefits are guaranteed. Clients could benefit from other
changes in the program which may result from the process evaluation.

There is no risk or deception involved. Maureen will discuss her observations with the program staff to ensure they are accurate and obtain necessary clarification. No names will be used in any of the documentation or discussions. Field notes will be kept at M. Laurie's home, in a locked filing cabinet. For more information on the study, contact Maureen at 655-4734 or her research supervisor at the University of Saskatchewan, Department of CH&E, Kathryn Green, at 966-7839.

A summary of the evaluation results will be available to staff at the completion of the study. They will also be invited to attend the presentation made to Sexual Health staff regarding the Street Outreach evaluation.

I understand what is involved in the process evaluation and this consent form. I consent to Maureen Laurie observing Street Outreach staff delivering services in the mobile van, at times to be arranged with the program supervisor [for Healthy Lifestyles Manager and Street Outreach supervisor] I agree to let Maureen Laurie observe my work with Street Outreach in the mobile van, with the understanding that I will be informed in advance of the times she will be observing me [for staff]. I have been given a copy of this form to keep.

Signature/Position

M. Laurie Date:
Appendix C
Information Sheets About Evaluation Study

Street Outreach Evaluation Information Card (to be given to clients prior to the evaluation study)

To all Street Outreach Clients who get needles:

(to be given to clients accessing needles at the STD clinic, pharmacy, or the van prior to the start of the evaluation)

Street Outreach Evaluation

When? February to April 1, 1998.

Where? STD clinic (100-310 Idylwyld Drive N.) every day from February 9th to 13th (9:00 a.m. to 5:00 p.m.) and every Wednesday afternoon (1:00 to 4:30 p.m.) from then to April 1st OR at the van

Why? It will give us a better idea of who we are serving and how we could improve our service
It is your opportunity to tell us what you think of the service

How can you take part?
Come to the STD clinic at the times listed and ask for Maureen OR talk to the outreach workers. You can call Maureen at 655-4642 for more information, too. You need to know your client number to take part.
(Ask the outreach workers if you don’t know your number).

How long will it take? About 20 to 30 minutes

We will pay you $20.00 for your time and effort.

Street Outreach Evaluation Card (to be given to participants following the questionnaire)

If you have any further questions, call Maureen at 655-4642 or ask for her at the STD clinic (100 310 Idylwyld Drive N.).

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# Appendix D
Protocol for Observations

<table>
<thead>
<tr>
<th>Activity</th>
<th>Physical Environment</th>
<th>Social Environment</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needle Exchange</td>
<td>(time, where,</td>
<td>(who’s talking,</td>
<td>(usual/ unusual activity, what happened, how I felt, what staff said about it)</td>
</tr>
<tr>
<td></td>
<td>description of client)</td>
<td>frequency, topic)</td>
<td></td>
</tr>
<tr>
<td>Condom Distribution</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Information</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client Referral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Testing/Immunizing</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix E
Client Survey
Client Survey

<table>
<thead>
<tr>
<th>Date of Interview</th>
<th>Client Identification code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Interviewer ________________________________

Site of Interview: Van 1
STD clinic 2

Eligibility Criteria:

Registered client with Street Outreach
[ ] Yes
[ ] No (If no, do not continue)

Injection drug user currently or within past 6 months
[ ] Yes
[ ] No (If no, do not continue)

Instructions for Interviewers:

Introduce yourself: Tell the participant about:

i) the purpose of the evaluation (program has never been evaluated; being done to make improvements in programming)
ii) your role in the evaluation (helping the evaluator by interviewing)
iii) their important role in making this evaluation a success (as clients, their feedback about the Street Outreach needle exchange service will be extremely helpful to Public Health Services.

Thank them for their participation.

Tell the person it will take anywhere from 20 to 30 minutes to conduct the interview and there will be a lot very personal questions about their sexual and injection practises.

Going through the consent checklist item by item will ensure that all of these points are covered.
Appendix B

Consent for Observing Street Outreach Staff
Consent Checklist

1) Participation in the survey is voluntary. You can drop out at ANY time during the interview. Withdrawal will not affect access to any services.

2) The information you give is strictly confidential. If for any legal reasons we have to release this information, no identifiers are being used. Your name or client number will not appear or be linked to your answers in any future reports.

3) The findings from the survey will be made available to Public Health Services in the form of a summary report. The findings will help Public Health Services to know who they are serving; what changes are needed to improve services; and what other prevention programs may be required to meet the needs of the clients they serve. There is no guarantee that any changes will be made to the Street Outreach program as a result of your suggestions. As well, the study findings will be used in the thesis of the researcher, Maureen Laurie. A summary of the survey findings regarding the client satisfaction questions will be available from the Street Outreach staff when the study is completed. The results of the study may be reported by the researcher in subsequent publications, but only aggregate data findings will be used. No names or other identifiers will be used in any of these reports.

4) If you have any further questions about the study, you can call 655-4642 and speak to Maureen. Her number is on the card or information sheet; you can have whichever you prefer to take with you as a reminder of your participation in the study.

5) You do not have to answer every question to receive the $20.00; however we must go through the entire questionnaire before you get the money. By taking the money, you are consenting for us to use the information in the report as I have indicated.

6) If you wish to access other services such as HIV testing, Hepatitis B immunization, or STD check up, we will help you to do that.

I have completed the consent checklist with this participant. He/she has indicated an understanding of all the points in the checklist and is willing to continue with the protocol.

Interviewer’s signature ___________________________ Date: ___________________________

If someone does not want to continue, please note approximate age (do not ask) and gender. Ask the client to indicate the main reason for refusal (e.g., don’t feel comfortable, interview is too long). If client is hesitant to answer, do not probe further.

Approximate age _____ Gender _____ Ethnicity _______________________

Reason for not participating:

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

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Thank you for agreeing to take part in this evaluation. From your feedback, we may be able to make some improvements in the Street Outreach needle exchange service and to develop some better prevention programs.

In this interview I will be asking you a lot of very personal questions - about yourself and your lifestyle. Everything you tell me during this interview will be kept totally confidential. I do not want to know your name, or the names of anyone else we will be talking about.

At the end of the interview, I will pay you for your time and effort.

First, I will begin by asking you some general questions about your age and where you live.

1. When were you born? ☐
   (year) [ ]
   Age [ ]

2. What sex are you?
   ☐ Female 1
   ☐ Male 2

3a. How long have you lived in Saskatoon? ☐
    years or [ ]
    months [ ]

3b. Where did you live before coming to Saskatoon? _______________________
    N/A 1

4. What cultural background do you identify yourself with? ☐
   ☐ White 1
   ☐ Black 2
   ☐ Aboriginal 3
   ☐ Asian 4
   ☐ Other ➔ _______________________

5. What is the highest level you finished in school?
   (If in school, use the current level)
   ☐ None 1
   ☐ Elementary (K to 6) 2
   ☐ Junior high (grades 7 to 9) 3
   ☐ High school (grades 10-12) 4
   ☐ Trade school 5
   ☐ University 6
   ☐ Other ➔ _______________________

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6. What kind of housing do you live in now?
ONLY 1 ANSWER

- Apartment, duplex or house
- Hotel/motel room
- Shelter
- Transition house/halfway house
- Friend’s place
- Parent’s place
- Street
- No fixed address

- Other → ________________________________

7. Are you employed?

- Yes, regular employment
- Yes, casual employment
- No

8. What kind of relationship are you in right now?
ONLY 1 ANSWER

- Married
- Common Law
- Divorced/Separated
- Single
- Widowed
- Same sex partner

- Other → ________________________________

9. Have you ever been in jail, prison or a detention centre overnight or longer?

- Yes
- No

Suggested Introduction:
- In these next questions, I’d like to talk about your drug use - when and why you started using, and what your lifetime injecting experience has been.
- This information is important for us to know so that we can work with you to improve our service.
- Remember, everything you tell me is confidential.

Note to interviewers:
The objective of this section is to get an idea of the person’s lifetime experience with injecting, and then to focus on the most recent period of regular use within the past 6 months.
10. How old were you when you first used needles? 
NEEDLES, NOT DRUGS; USED, NOT SHARED.

11. How did you get into it/ What got you started? (Do not read from the list)
- Friends/Partner introduced me to it
- Liked getting high/partying
- Experiment- curious, interested/ wanted to try
- Chronic pain
- Stranger introduced me
- Don’t know/forgotten

☐ Other → ____________________________

12. Which drugs have you injected?

13. Which drugs have you injected the most?

14. How long have/had you been using needles? 
USING, NOT SHARING.

☐ Other → ____________________________

15. When was the last time you used needles? (Do not read from the list)
- today
- 1-3 days ago
- 4-6 days ago
- 1-2 weeks ago
- between 2 weeks & 1 month ago
- between 1 month and 6 months ago

☐ Other → ____________________________

16a. Have you ever used a needle that someone else used, including your partner? (Ever in your entire life?)
- No
- Unsure
- Yes →

224
16b. Who had used the needle before you?
   □ Partner  1
   □ Friend  2
   □ Stranger  3

   □ Other  → ___________________________

17a. Have you shared other drug injection equipment with anyone, even your partner?
   □ No  2
   □ Unsure/don’t remember  3
   □ Yes  →  1

17b. What drug injection equipment have you shared?
   (Go through each one in the list)
   □ cotton/filter  1
   □ spoon  2
   □ water  3
   □ syringe  4

17c. How often has this happened in the last 6 months?
   □ Always  1
   □ Usually  2
   □ Sometimes  3
   □ Hardly ever  4
   □ Never  5

18. Have you ever let someone else use a needle that you have used, including your partner?
   □ Yes  1
   □ No  2
   □ Unsure  3

19. Have you ever used needles in groups of people?
   □ Yes  1
   □ No  2
   □ Don’t remember  3

20a. Have you ever injected in another city?
   □ No  2
   □ Yes  →  1

20b. Where? __________________________

20c. When? __________________________
21. In the last 6 months, where did you get new needles?

- van 1
- STD clinic 2
- Hewgill's Pharmacy 3
- Friend/Partner 4

- Other → _______________________

22. Why do you usually get them from there? (Do not read from the list)

- Free needles 1
- Convenient (live close by) 2

- Other → _______________________

23a. Do you get new needles for other people?

- No 2
- Yes → 1

23b. How many people do you get needles for? [ ]

23c. Who do you get needles for?

- Friends 1
- Partner 2

- Other → _______________________

24. How many needles do you usually get at each visit? [ ]

- Box (100) 100

25a. Do you know other people who use needles that don't get them from Street Outreach?

- No 2
- Yes → 1

25b. Why do you think they don't get new needles from Street Outreach?

- Unsure 3

- Other → _______________________

26. Do you drink alcohol on a regular basis?

- Yes 1
- No 2

27. Have you ever used solvents on a regular basis?

- Yes 1
- No 2

226
Suggested Introduction:

- You have told me when you started using, and some of the reasons why you started, what you have used.
- Now I want to ask you some detailed questions on your most recent regular use within the last 6 months. By regular I mean when you were into it, not just a one time thing or a relapse.

Note to the interviewers: This section refers to regular injection use within the last 6 months.

28. Which drugs do you/did you use on a regular basis?

<table>
<thead>
<tr>
<th>Drug</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Cocaine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Heroin</td>
<td></td>
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<tr>
<td>Yes</td>
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<td></td>
</tr>
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<td>No</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Ritalin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>T &amp; R</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Crack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

29a. During the past 6 months, on average, how many TIMES A DAY did you inject? 

29b. During the past 6 months, on average, how many DAYS A WEEK did you inject? 

29c. During the past 6 months, on average, how many DAYS A MONTH did you inject? 

30a. In the past 6 months, did you use needles that someone else had already used?

<table>
<thead>
<tr>
<th>Choice</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Unsure/don’t remember</td>
<td>3</td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
</tbody>
</table>
30b. How often does this/did this happen?

- Always  1
- Usually  2
- Sometimes  3
- Hardly ever  4
- Never  5

30c. Why do you/did you use needles that someone else had already used?

30d. When you used a needle that someone else had already used, how often did you clean the needle before you used it?

- Always clean it  1
- Usually  2
- Sometimes  3
- Hardly ever  4
- Never  5

31a. Do you/did you find it hard to get new needles whenever you need them?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
</tbody>
</table>

31b. Why is that?

32a. If there were always new needles available to you, would there be any situations where you would still share needles?

<p>| | |</p>
<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Unsure</td>
<td>3</td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
</tbody>
</table>

32b. Can you tell me about this?

33. How many OTHER people are usually with you when you use? [ ]
34a. Do you usually use in groups with strangers?

☐ No 2
☐ Unsure 3
☐ Yes → 1

34b. Can you tell me about this?

34c. In this situation, would you use needles that someone else had already used?

☐ Yes 1
☐ No 2
☐ Unsure 3

35. How do you/did you clean needles? Get a step by step description, solutions used, ASK how long solution left in, if needle was flushed, number of flushes. ☐ N/A 1

36. What do you usually do with a needle when you have finished with it; when you can’t use it any more? Get a step by step description; ASK if they recap the needle.

37a. If you have been in prison, did you ever use needles?

☐ No 2
☐ Yes → 1

37b. Did you use needles someone else had used?

☐ No 2
☐ Yes → 1

37c. Did you clean the needles before using them?

☐ No 2
☐ Yes → 1
37d. What did you clean them with?

- Water 1
- Bleach 2
- Alcohol 3
- Other → ______________________

38. I’ve asked you some pretty detailed questions about your drug use.

How good would you say your memory is on this stuff?

<table>
<thead>
<tr>
<th></th>
<th>very poor</th>
<th>poor</th>
<th>not bad</th>
<th>pretty good</th>
<th>really good</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
- Don’t know 0

Note to interviewers:
The objective for this section is to get the most recent picture of a person’s sexual behaviour.

Suggested Introduction For Sexual Behaviour Section

- You have told me a lot about your using needles, now I’m going to ask you some very personal questions about your sexual partners. Please remember this is completely confidential information. I do not want to know your name or the names of any of your partners.
- I’m going to ask you about regular, and casual sexual partners. A regular partner is someone you have had a sexual relationship with for at least 3 months. A casual partner is someone you have had sex with for less than 3 months. This includes one night stands.
- Your information is important to us so that we can provide the best service we can.

I’d like to start with some general questions about your sexual partners.

39. Do you have sexual partners (within last 6 months)?
- No → Go to # 49b 2
- Yes → 1

40. Have you exchanged sex for drugs or a place to sleep in the past 6 months?
- Yes 1
- No 2

41. Have you been paid for sex within the past 6 months?
- Yes 1
- No 2

230
42a. Do you use condoms for vaginal sex with your regular partners?
   - No 2
   - Doesn’t have vaginal sex with regular partners 3
   - Yes → 1

42b. How often do you use condoms for vaginal sex with your regular partners?
   - Always 1
   - Most of the time 2
   - Hardly ever 3

43a. Do you use condoms for anal sex with regular partners?
   - No 2
   - Doesn’t have anal sex with regular partner 3
   - Yes → 1

43b. How often do you use condoms for anal sex with your regular partners?
   - Always 1
   - Most of the time 2
   - Hardly ever 3

44a. Do you use condoms for vaginal sex with your casual partners?
   - No 2
   - Doesn’t have vaginal sex with casual partners 3
   - Yes → 1

44b. How often do you use condoms for vaginal sex with your casual partners?
   - Always 1
   - Most of the time 2
   - Hardly ever 3

45a. Do you use condoms for anal sex with casual partners?
   - No 2
   - Doesn’t have anal sex with casual partners 3
   - Yes → 1

45b. How often do you use condoms for anal sex with your casual partners?
   - Always 1
   - Most of the time 2
   - Hardly ever 3
46. **Do you use condoms for oral sex with your regular partners?**

- Yes, always 1
- Yes, most of the time 2
- Hardly ever 3
- No 4
- Doesn’t have oral sex with regular partners 5

47. **Do you use condoms for oral sex with your casual partners?**

- Yes, always 1
- Yes, most of the time 2
- Hardly ever 3
- No 4
- Doesn’t have oral sex with casual partners 5

48. **If you don’t use condoms, what are some of your reasons for not using them?** *(Do not read from the list)*

- My partner doesn’t like them 1
- I don’t like them 2
- No reason to use a condom; trusting relationship 3
- Other

49a. **How many sexual partners have you had in the past month?** [ ]

49b. **How many sexual partners have you had in the past year?** *(approximately)* [ ]

49c. **How many sexual partners have you had in your life?** *(approximately)* [ ]

*If they are unable to answer, try to get a range (e.g., < 50 or > 250)*

50. **How many of your sexual partners were injection drug users?** [ ]

- Don’t know 0

51. **Are your partners:**

- Male 2
- Female 1
- Both male and female 3

232
52a. Have you ever been in treatment or a healing/recovery centre for addiction in Saskatoon?

- [ ] No 2
- [ ] Yes 1

52b. What kind of treatment were you in? (Do not read from the list)

- Detox 1
- Rehab 2
- Methadone maintenance 3
- Other 0

52c. Were you able to get the help you needed?

- [ ] No 2
- [ ] Yes 1

(If they mention being referred for treatment, ask who they were referred by & document the agency under the comments section).

Comments:

53. What are some signs and symptoms of a sexually transmitted disease?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Pain when you pee</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Ulcer (sores on your genitals)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Bumps in your genital area</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

I'd like to ask you just a few general questions about HIV/AIDS and Sexually Transmitted Diseases. This section will help us in planning prevention programs so people don't get infected with HIV or STDs.
54. In your opinion, how do people get HIV or the virus that causes AIDS? *(Do not read from the list; get a yes/no for anal, oral & vaginal sex)*

- Sharing injection equipment
- Anal sex (unspecified)
- Oral sex (unspecified)
- Vaginal sex (unspecified)
- Anal sex (unprotected)
- Oral sex (unprotected)
- Vaginal sex (unprotected)
- Injecting drugs
- Blood
- Tattooing/ear piercing
- Saliva (kissing, toothbrush)

☐ Other → _______________________________________

55. How can people protect themselves from getting HIV? _______________________________________

56. Given your current injection practices, what do you think your chances are of getting HIV? *(Read options)*

- pretty high
- about average
- pretty low

57. When, if at all, were you tested for HIV or the virus that causes AIDS? *( ) years or [ ] months*

58. In your opinion, how do people get Hepatitis B?

- Unsure
- Unprotected Sex
- Sharing needles

☐ Other → _______________________________________

59. In your opinion, how do people get Hepatitis C?

- Unsure
- Unprotected Sex
- Sharing needles

☐ Other → _______________________________________

234
60. Have you ever been tested for Hepatitis B and C?
   □ Yes, both 1
   □ No 2
   □ Just Hepatitis B 3
   □ Just Hepatitis C 4
   □ Unsure 5

61. Have you ever been vaccinated against Hepatitis B?
   □ Yes 1
   □ No 2
   □ Unsure 3

We're almost finished with the interview. I would just like to finish by asking you for your opinion about the Street Outreach needle exchange service. We are doing an evaluation of the service and because you are a client, we want to hear what you think about it. Please remember, all you tell me is confidential and your answers will only appear as one of many in the final report.

62. What are your reasons for using the needle exchange? (Do not read from the list)
   □ Convenience 1
   □ Free needles 2
   □ Other →

63. Have you ever received any of the following from an outreach worker in the van? 
   Check as many as listed by participant. (You may read the list.)
   □ Needles 1
   □ Condoms/lubricants 2
   □ Information about getting HIV/AIDS by sharing needles 3
   □ Information about getting HIV/AIDS through sexual activity 4
   □ Information about getting Hepatitis B or Hepatitis C 5
   □ Information about the safe disposal of needles 6
   □ Help in getting counselling or treatment for drug related problems 7
   □ Testing for HIV 8
   □ Testing for Hepatitis B and C 9
   □ Hepatitis B vaccine 10
   □ Other → specify
64a. Have you changed anything in your injecting practices since you've been getting needles from street outreach? □ No 2
□ Yes  1

64b. What have you changed? ______________________________________________________

65. What do you like best about the street outreach service? ______________________________________

66. What do you like least about the street outreach service? ______________________________________

67. If we could make changes in the street outreach service, what would you like to see us change? ______________________________________

68a. I'm going to read a list of services provided by the workers in the van. Please rate each of them on a scale from very poor, poor, not bad, pretty good or really good.  

*Use the following scale as a guide to each service.*

<table>
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<tr>
<th>very poor</th>
<th>poor</th>
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 Doesn't use the van  99
68b. What would be better? Hours/Days

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<td>Number &amp; types of services offered (e.g., referrals, testing, immunizing, free condoms)</td>
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69. I'm going to read a list of services provided at the STD clinic. Please rate each on a scale from very poor, poor, not bad, pretty good or really good.

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<td>Number &amp; type of services offered (e.g., referrals, testing, immunizing, free condoms)</td>
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Comments: __________________________________________________________
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Note to the interviewers: Use the same scale as above to rate each of the following services.
Use the following scale as a guide to each service.

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70. I'm going to read a list of services provided at Hewgill's. Please rate each on a scale from very poor, poor, not bad, pretty good or really good.

☐ Doesn't use Hewgill's Pharmacy 99

☐ Hours for exchange
☐ Location convenience
☐ Privacy of location
☐ Staff
☐ Educational information available

☐ Aware of this service

Comments: ____________________________________________________________

☐ Yes 1
☐ No 2

Suggestions for conclusion of interview:
Thank you for taking part in this survey. Your feedback will be helpful to us when we look at how we can improve the street outreach service and plan for future prevention programs.
Remind the client that a summary of the survey findings regarding the client satisfaction questions will be available from the street outreach staff when the study is completed; around September. No names will be used in any of the reports.
For your time and effort, I will give you $20.00. Have her/him sign their registration number in the accounting book provided to verify that they received the $20.00. Give her/him a card or information sheet about the survey (whatever she or he would like to take away at this time).

How did you hear about the needle exchange program?

Other comments: ______________________________________________________

_________________________________________________________________
Appendix F
Client Statistical Record
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Other Activities: Meetings Groups

241
The University Advisory Committee on Ethics in Human Experimentation (Behavioral Sciences) has reviewed the revisions to your study, "A Process Evaluation of the Street Outreach Needle Exchange Project of Saskatoon District Health, Public Health Services" (98-06).

1. Your study has been APPROVED.

2. Any significant changes to your protocol should be reported to the Chair for Committee consideration in advance of its implementation.

3. The term of this approval is for 3 years.

David Hay, Chair
University Advisory Committee on Ethics in Human Experimentation Behavioral Sciences

Please direct all correspondence to:

Ronnie Korthuis, Secretary
UACEHE, Behavioral Science
Office of Research Services
University of Saskatchewan
Room 210 Kirk Hall, 117 Science Place
Saskatoon, SK S7N 5C8
Appendix H
Initiation into injection drugs – client stories
The question from the client survey that sparked most of the interesting conversations with the injection drug users was open-ended. I asked, “How did you get into it (using needles)? What got you started?” Although the answers were usually straightforward and did not require much as far as analysis, the stories provided me with insight into their lives as injection drug users. I would like to share a few of their stories. All the names used in this section are pseudonyms.

*Ben’s Story*

Meet Ben. He is a young Aboriginal man about 28 years old who came to the clinic to be surveyed. He was dressed neatly in grey sweats, a brown leather jacket with a sports logo crest across the back, and well-worn Nike running shoes. Ben was well groomed, with collar length black hair and a red bandana around his forehead. He looked like a typical young fellow – the type you might meet anywhere in Saskatoon. Unlike many other young men, Ben was an injection drug user and had been for the past fifteen years.

Ben’s drug use began when his parents were both hospitalized and he was sent to live with an aunt and uncle. He was ten years old. He started by using drugs more commonly known as ‘smoke dope.’ Eventually, while attending a party with a bunch of his friends and relatives, he tried injection drugs. Ben remembered them laughing and taunting him not to be such a ‘chicken’ and to try injecting. It took only one time, and he was hooked. He has been using injection drugs ever since.

During the interview, Ben told me that he was not on the methadone program and
did not think that he needed to go on it in order to quit using. He talked about getting
spiritual direction from the elders and that what he needed most to quit, was the belief in
himself that he could quit. He commented, with strong conviction, that he would be able
to ‘beat this’ by himself one day. I hope he does.

Getting clean is important to Ben, so that he can eventually get his children back.
As he was telling me about his children, he pulled their pictures from his wallet to show
me. Although he said his son was 12 and his daughter 8, the pictures he showed me had
been taken years ago. He talked about his children and his dreams to play National
League Hockey – both lost because of his drug use. Apparently he had played triple A
hockey at one time and had enough talent to go on to play professional hockey. His
lifestyle of injection drug use stole his chances for success, robbing him of both his
dreams and his kids.

Michael’s Story

Meet Michael, a 42- year-old Caucasian who came to the clinic to be interviewed.
Michael’s story is a little different because he has only been an injection drug user for a
few years. Up to that time, Michael was a successful business man. He told me he had a
prominent job that paid him $80,000 per year and he wore expensive, tailor-made suits
rather than the t-shirt and jeans he wore the day I met him.

Michael had surgery following a motor vehicle accident. Due to chronic pain
following the surgery, he had to take MS Contin (a morphine analgesic). After being on
the morphine for some time, his friends showed him how to make the pill soluble and
how to inject it, making it more effective. Within a year, Michael was totally addicted to
injecting morphine. In conjunction with alcohol abuse, he quickly lost his lucrative job
and his family, and joined the group of what he called ‘responsible junkies’. What he
meant was that his group of injection drug users is responsible and safe about their
injection practices. They never re-use needles or share them, unlike those he referred to
as ‘street junkies.’ Michael feels hopeful that he will be able to stop injecting soon. He
is in treatment for his alcoholism and re-establishing a relationship with a former
girlfriend. He thinks this may give him the strength he needs to stop.

Julie’s Story

Meet Julie. She is a 21-year-old Aboriginal woman with sparkling brown eyes
and long dark hair. She is so beautiful, she could easily be a model. Julie is HIV-
positive and just beginning to show signs of super-infection in her mouth. She still uses
needles, although she no longer works the streets. She has a ‘mark’, someone who takes
care of her.

When I asked Julie how she got into using needles, her story touched me most of
all. She explained that she was passed from foster home to foster home during her early
years. When she was 13 years old, her step-father introduced her to needles. He fixed
for her the first few times until she was brave enough to fix for herself. He also provided
her with drugs and the necessary injection equipment. After a couple of weeks, Julie’s
step-father told her he could show her how she could make enough money to buy her
own drugs. At the age of 13, Julie became a sex trade worker, living on the streets. She
travelled between Saskatoon and Vancouver, Edmonton, and Calgary working the streets and fixing. Somewhere along the way she became infected and by the time she was 16 years old, Julie was HIV- and hepatitis C- positive.

Somehow, at 21, she seemed resigned to her fate. I didn’t sense anger or resentment for her situation, but rather a bizarre acceptance of the past. The last time I worked in the van observing, I saw Julie. She immediately came up to the van to talk. Before leaving, she told me that she had used the $20.00 she got for doing the interview to buy groceries. I have no idea whether or not that is true. I would like to believe it is.
Appendix I
Comments

Comments from survey respondents regarding Street Outreach. A brief demographic description precedes the comments.

Comments about Street Outreach program

A 46-year-old woman who has been using needles since she was 11 years old commented: “(I) think the service van provides is super and wish more other people would use it rather than running around to find needles or re-using.”

A 43-year-old women who moved recently from Ontario and has been using needles for 20 years thought: “... program we have is very good in this city.”

A 37-year-old male who began using needles at the age of 19 commented: “Good idea for a program.”

A 43-year-old female injection drug user from Saskatoon. “When the van is not out everything is affected. If funding is pulled, we’d be devastated.”

A 26-year-old female who has been injecting drugs for the past 10 years said, “(I) think Street Outreach is doing a pretty good job and hope others will get to hear about (their) work. That way they can be saving a lot of lives.”
Comments about the Street Outreach staff

A 29-year-old male who has been using needles since 15 had this to say: “I think it’s good to see you guys out there helping.”

A 35-year-old female who began using needles three or four years ago as a result of chronic pain commented: “Really appreciate the service... helped me a lot. Very supportive, there for us with family not around.”

A 51-year-old female who has been using needles for 30 years. “Don’t fire the workers.”

A 36-year-old male who began injecting drugs at 23 years liked what the staff do and commented, “keep educating people.”

A 43-year-old male who had been injecting for 30 years commented: “Friendly, no backstabbing. And they don’t frown on you if you’ve been in jail.”

A 38-year-old hepatitis C-positive male said, “... I see someone cares and (they’re) around and I feel good out there knowing they care.”

A client who is HIV-positive and hepatitis C-positive commented: “You can tell them anything.”
A 31-year-old female said, "The workers care about us . . . never felt stigmatized, labelled, or judged."

Another 34-year-old female commented: "... don't make you feel like some low-life."

A 17-year-old male who has been injecting drugs for about a year commented: "They don't preach that you're bad for using drugs."

A 51-year-old female who began injecting at 21 said, "We could talk to you without feeling that you're intruding in our personal lives. You don't make us feel like we're worthless. We're a very closed [sic] family."

Comments about the interview

A young woman who works as a sex trade worker, commented: "This was kind of fun. The money is a bonus!"

An 18-year-old injection drug user. "Thanks for doing the interview and keeping me straight for awhile. Right on! (I) can use this $20.00 now to buy food . . . just no food in the house."

A man in his 30's who had been on injection drugs since his teen-age years commented: "This wasn't so bad. Nice talking to you. Can I come back sometime and talk to you
again?"

A 17-year-old female who works the streets occasionally when she needs the money said, "Is that all? I enjoyed doing this."

A 27-year-old female interviewed by one of the Street Outreach workers. "Good interview. Take care."