



National Collaborating Centre
for Infectious Diseases

Centre de collaboration nationale
des maladies infectieuses

OUTREACH PLANNING GUIDE

For Infectious Disease Practitioners
who work with Vulnerable Populations

SEPTEMBER 2010

National Collaborating Centre for Infectious Diseases

413-445 Ellice Avenue

Winnipeg, Manitoba

R3B 3P5

P: (204) 943-0051

F: (204) 946-0927

Production of this document has been made possible through a financial contribution from the Public Health Agency of Canada. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada. NCCID is hosted by the International Centre for Infectious Diseases.

PREFACE

The purpose of this Guide is to **present an evidence based conceptual model designed to guide the planning of outreach activities**. The model was developed based on information from a scoping review completed in September 2009 and follow up consultations held in 2010.

This guide has been developed by the **National Collaborating Centre for Infectious Diseases (NCCID)** for:

1. Communicable disease program managers and supervisors who use outreach as a way to reach vulnerable populations
2. Outreach staff
3. Groups representing vulnerable populations that are involved in outreach activities

The Outreach Guide focuses on the challenges faced by those planning outreach. **The guide is not step by step instructions to be followed in order but rather identifies issues to be considered at different stages of the outreach program. It functions as a tool for reflection and decision making. Its purpose is to assist practitioners working with vulnerable communities in planning by identifying the broader issues related to outreach while respecting the importance of customizing outreach activities to the specific needs of the population, disease or location.**

HISTORY OF THE PROJECT

In 2008, the NCCID hosted two Forums: *Building and Exchanging Knowledge for Reaching Vulnerable Populations* (February 2008, Montreal, Quebec) and *Increasing the Impact of HIV and STBBI Prevention* (March 2008, Toronto, Ontario). Discussion at the Forums highlighted the need for a national perspective on outreach, outlining the components of a 'good' outreach program while allowing room for flexibility and innovation in adapting it to local context and target populations. It was also acknowledged that there are many good, but little known programs across Canada. Sharing lessons learned from these programs, can contribute to the development of outreach programming across Canada.

A review of the scientific literature also found little evidence on the effectiveness of outreach in delivering health or social service programming. Similarly, a review of available program documentation and discussions with practitioners revealed a shortage of literature on the design and management of effective outreach programs. This lack of work on the fundamental program questions is in contrast to the wealth of technical guidance on specific subjects (e.g. testing) and detailed "how-to" staff manuals. Yet, anecdotal reports from practitioners indicate that the design and management of outreach programs is as important to success as the choice of approach, model, or technical expertise.

As a result of these conclusions, NCCID commissioned a scoping review of the evidence related to planning an outreach program. The review focused on sources related to planning and managing outreach specifically for the prevention and treatment of sexually transmitted and bloodborne infections including HIV (HIV/STBBI), it also included sources from other fields (such as mental health and addictions) that were considered relevant. This Guide is based on the information from that review, as well as feedback from national consultations.



TABLE OF CONTENTS

PREFACE	i
UNDERSTANDING OUTREACH	1
DEFINING OUTREACH	2
A CONCEPTUAL MODEL FOR OUTREACH	3
STEP 1: GET TO KNOW YOUR POPULATION	5
1.1 Build a vulnerable population profile	5
1.2 Assess the situation	6
1.3 Engage vulnerable community members	7
STEP 2: DESIGN YOUR OUTREACH PROGRAM	9
2.1 Develop a conceptual framework and define your program	9
2.2 Consider ethical, legal and risk management issues	12
2.3 Develop policies, procedures and guidelines	15
2.4 Consider staffing and staff development needs	16
STEP 3: DELIVER THE SERVICES	20
3.1 Manage the program	20
3.2 Integrate services	20
3.3 Mobilize the community	22
3.5 Build capacity and advocate	23
STEP 4: MEASURE THE RESULTS	26
4.1 Develop a performance measurement framework	27
4.2 Monitor Progress	28
4.3 Share results and celebrate	28
CONCLUSION	29



TABLE OF CONTENTS *(continued)*

REFERENCES	30
APPENDICES FOR OUTREACH GUIDE	34
Appendix A: Glossary	35
Appendix B: Defining Risk and Vulnerability	37
Appendix C: Harm Reduction Principles	38
Appendix D: Theory of Behaviour Change	39
Appendix E: Canadian Data Sources Specific to Vulnerable Populations	42
Appendix F: Geographic Mapping Feasibility Study	43
Appendix G: Documenting a Situational Assessment	44
Appendix H: Logic Models	46
Appendix I: Conceptual and Programming Challenges for Outreach	49
Appendix J: “Duty to Warn”	54
Appendix K: Organizational Factors That Support Positive Work Environments	55
Appendix L: Outreach Worker Qualifications	56
Appendix M: Nine Circles Outreach Worker Support	57
Appendix N: Partnership Synergy	58



UNDERSTANDING OUTREACH

Traditionally, outreach to vulnerable communities has been understood as “*the process of locating, contacting, and recruiting groups that are invisible, hidden, or otherwise difficult to engage in a program*”¹ and the provision of “...information about the nature of the concern, what can be done about it, and how services can be obtained”².

This requires **engaging with vulnerable people in their own environment to provide information and services on-site and to mobilize them back to existing fixed-site services** (e.g., clinics). Recently, these have been joined by a third focus: **community building**, which links the work of dealing with people’s immediate concerns (e.g., health), with the need to address the broader inequalities and vulnerabilities associated with the social determinants of health. Those on the margins of society are more likely to report lower levels of self-assessed health, visit hospital emergency departments more frequently, have a chronic disease and/or mental illness, attempt suicide more frequently, engage in destructive behaviours, and report difficulties accessing health services.^{3,4}

The Street Health Report 2007 on Toronto’s homeless population reported the following:

- Half those surveyed had experienced serious depression and a tenth had attempted suicide
- A third had been physically assaulted and a fifth of women had been raped or sexually assaulted
- Three quarters had at least one chronic or on-going physical health condition
- 29x more likely to have Hepatitis C than the wider Toronto population; 300x more likely to have HIV
- More than a quarter had been refused health care in the past year because they had no health card
- More than a third felt they had been unfairly judged or treated with disrespect by a health care provider and a fifth felt negatively treated by hospital security staff

Khandor E, Mason K. The street health report [Online]. 2007 [cited 2010 Mar 1]. Available from: URL:<http://www.streethealth.ca/Downloads/SHReport2007.pdf>



DEFINING OUTREACH

Broadly defined, outreach:

- Delivers services to individuals and groups in their natural settings,
- Mobilizes and empowers individuals and groups to access mainstream or fixed-site services (e.g. clinics),
- Helps build community by connecting individuals, and
- Supports behaviour change

Outreach should bring services to clients or mobilize them to access the services they need. Building trusting relationships with clients is an important step. Cultural sensitivity and advocacy are inherent in outreach to support health equity. Outreach programs also recognize the difference between risk and vulnerability, distinguishing between the individual risk⁵ and the underlying vulnerabilities. See Appendix B for more information on defining “risk” and “vulnerability”.

Outreach promotes positive individual behaviours and the wider healthy community norms that support them. It focuses on both the reduction of immediate risks and the promotion of longer-term wellness among vulnerable populations who live on the margins of society and do not access traditional services.

WHY USE OUTREACH?

Evaluation research shows that successful outreach interventions are not only cost-effective, but also share several characteristics, including the use of theoretical behaviour change models, build behavioural skills, and are culturally sensitive. Duration and intensity of contacts, sustainability, and maintaining client stability and motivation are also important.⁶⁻⁹

It is important to note that a number of works in the literature talk about research gaps and the dangers of assuming that lessons learned from one disease, population or location can be automatically or easily applied to other situations.¹⁰⁻¹⁵

Evidence of the effectiveness of outreach as a programming approach to prevent and treat sexually transmitted and bloodborne infections including HIV (HIV/STBBI) among vulnerable populations generally does not yet exist. However, there is evidence of its effectiveness in preventing the spread of HIV among injection drug users (IDU) by promoting and supporting safer injection behaviour. The World Health Organization (WHO) reviewed over 40 evaluations of outreach interventions working with injecting drug users and concluded that outreach is:

...an effective strategy for reaching hard-to-reach, hidden populations of IDUs and provides the means for enabling IDUs to reduce their risk behaviours... and increase their protective behaviours; changes in behaviours have been found to be associated with lower rates of HIV infection.¹⁶



A CONCEPTUAL MODEL FOR OUTREACH

The model proposed here is based on a scoping review of scientific and grey literature and was modified following national consultations. It is designed to assist those planning and managing outreach activities in thinking through some of the broader issues related to outreach.

The principles of harm reduction (see Appendix C) and theories of behaviour change (see Appendix D) form the foundation for outreach services in this model.

The following four broad components were identified for inclusion in the conceptual model for outreach:

1. Assessment - Get to Know Your Population

2. Planning - Design Your Outreach Program

3. Implementation - Deliver the Services

4. Evaluation - Measure the Results

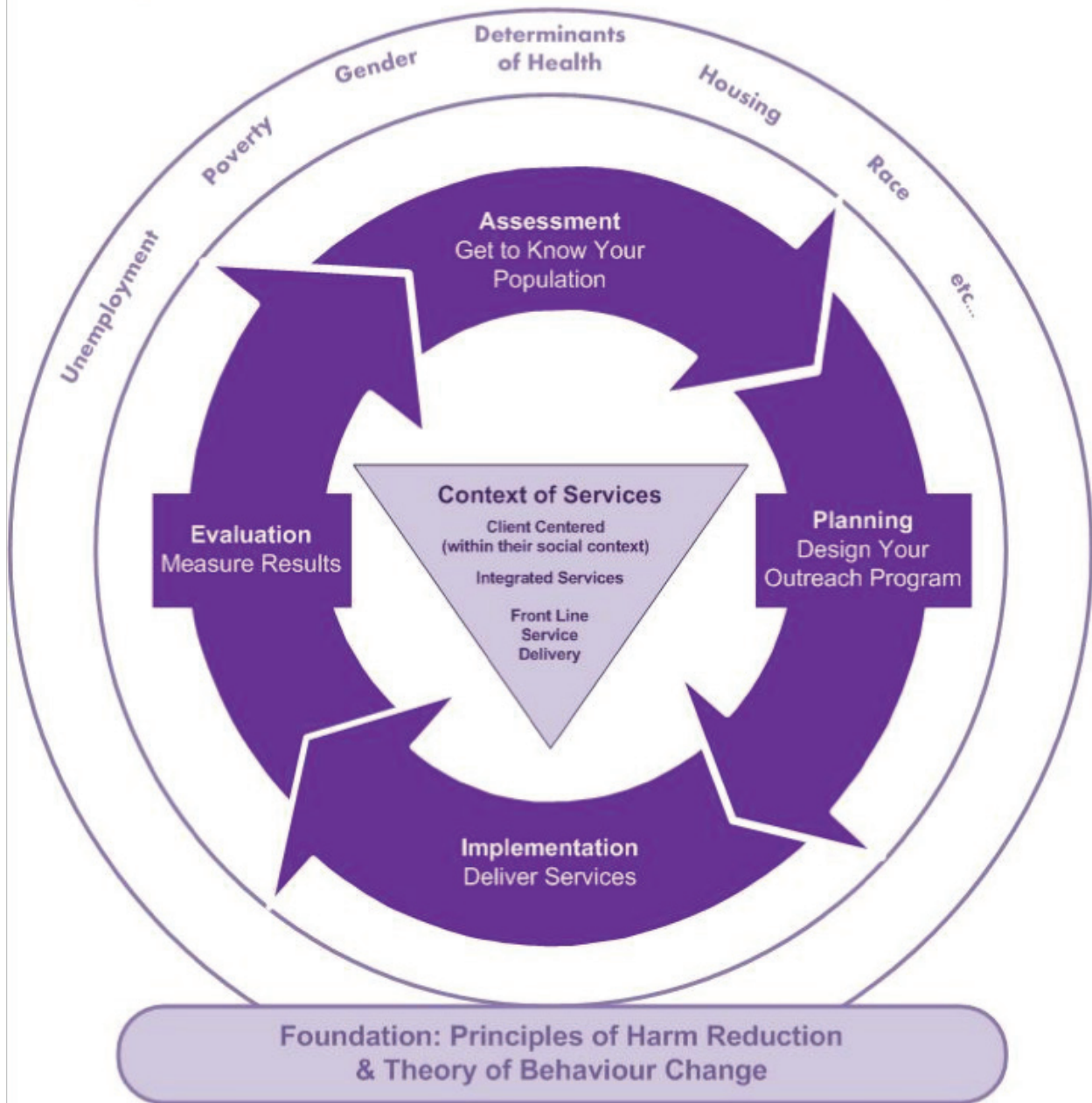
These four components are placed within the context of the determinants of health (the surrounding circle) highlights how the interaction between community-based services and social determinants of health shape services and risk reduction practices.¹⁷

The model also recognizes that the following three components are central to outreach delivery, and need to be considered in every step of the process:

- Client-centered focus with an understanding that broad social relationships and community contextual factors play an important role in shaping an individual's health
- Integrated services
- The reality of front-line service delivery and the recognition of the importance of front-line workers and the services they provide.¹⁷



Conceptual Model for Outreach to Vulnerable Populations



STEP 1: GET TO KNOW YOUR POPULATION

A review of program documents and discussions with managers indicate that many outreach programs would benefit from detailed population profiles and situation assessments while integrating research-based approaches. Engaging vulnerable community members are also key factors for success.

1.1 BUILD A VULNERABLE POPULATION PROFILE

The first step in developing an outreach program is to create a population profile (or picture of the population at risk) and to assess the programming situation.

Outreach planning should be based upon accurate knowledge on the size and location of key population groups, and outreach should ensure high coverage of the key populations at each location. Social mapping and situational assessment tools were also described as useful tools to identify the locations, estimate the number at each location and assess programmatic specific needs...¹⁸

A population profile is usually made up of:

- **Basic demographics (e.g., age, gender, sexuality, ethnicity, education, and income)**
- **Behavioural information (e.g., high risk sex, injection drug use)**
- **Health/illness data**

A population profile is usually made up of:

Creating a population profile makes it easier to develop baseline and target indicators for disease rates and associated behaviours, and to set targets for coverage and service delivery.

Some questions that vulnerable population outreach programs should consider asking are:

- What do we know about the basic demographics (i.e., characteristics) of our population, their behaviours (including networks), and their health status? Can we link the vulnerabilities present in our population to their known risk behaviours and situations? Can we identify the relevant social determinants of health?
- What is the size of the population we want to reach? Can we map their locations, times, and movements? Do we know when and where risk behaviour takes place? Is our coverage sufficient to change behaviours and stop transmission of infections?¹⁹
- What are the existing sources of data on our population? If the data does not exist, can we use available data from similar populations in homogeneous settings to develop a profile?



- What are the needs of our population and which of those needs are not being met? What is known about existing service providers and services, and the population's ability/willingness to access them?
- Can the available information be used to measure program performance, including coverage, effectiveness, and the impact of the program on behaviour and disease transmission?

In asking these questions, it is important to remember that the goal of a profile is to create a picture of a population to support the development of effective programming and performance measurement.

Collecting and analysing this information is an important step in planning. Some information may be available from other sources — in Canada, there is data for both general and specific vulnerable populations. (See Appendix E for a list of some available Canadian data sources specific to vulnerable populations.) Programs can also create their own data through the on-going collection of statistics (e.g., contacts, distribution of supplies, referrals) and regular behavioural and client satisfaction surveys.

Social mapping could help ensure that a maximum number of people of a hidden and marginalised group can be reached. As with social mapping exercises in other countries, the Winnipeg Mapping Feasibility Study exposed gaps between what service providers thought they knew about vulnerable population risks and needs and the actual risks and needs. See Appendix F to learn more about the lessons that were learned and recommendations from the Winnipeg High Risk Activity (HRA) Geographic Mapping feasibility study. Social mapping may not be feasible in all settings however.

1.2 ASSESS THE SITUATION

"A situational assessment influences planning in significant ways by examining the legal and political environment, stakeholders, the health needs of the population, the literature and previous evaluations, as well as the overall vision for the project. The phrase 'situational assessment' is now used rather than the previous term 'needs assessment.' This is intentional. The new terminology is used as a way to avoid the common pitfall of only looking at problems and difficulties. Instead it encourages considering the strengths of and opportunities for individuals and communities. In a health promotion context, this also means looking at socio-environmental conditions and broader determinants of health."²⁰

A situational assessment includes²¹, but is not limited to:

- Key facts, findings, trends, and recommendations from the literature,
- Data and analyzes obtained from population health assessment and surveillance,
- Legal and political environments,
- Stakeholder perspectives,
- Potential partners, and
- Recommendations based on past experiences, including program evaluation information.



In other words, situation assessments provide an overview of existing programs and help to determine whether outreach is the best approach to take. They also provide an opportunity to engage with the targeted vulnerable community to identify their needs and propose interventions thereby establishing a working relationship that will strengthen program delivery.²²

A major challenge when conducting a situation assessment is deciding where to start and what to assess. Current evidence indicates that it is important to consider program duplication²³ and to “benchmark local services”.²⁴

At the very least, situational assessments should answer the following questions at the individual, community, and organization level:

- What is the situation? (Consider trends, public perception, stakeholder concerns, etc.)
- What is making the situation better and what is making it worse?
- What possible actions can you take to deal with the situation?²⁴

Situational assessments should also:

- Show the positives (not just the needs or deficits),
- be the result of ongoing, meaningful input from vulnerable communities,
- look broadly and deeply at health issues,
- be complete, convincing, credible and compelling, and
- consider the Social Determinants of Health.²⁴

For more information about conducting a situational assessment, see Appendix G.

1.3 ENGAGE VULNERABLE COMMUNITY MEMBERS

One point that is consistently identified in the literature is that outreach programs need to find vulnerable community members and build relationships with them.

People who are vulnerable may have a complicated history of misunderstanding and distrust with service providers.²⁵ To meet these challenges, it is necessary to engage community members as partners in a shared cause, and recognize their rights to self-determination and participation in the decisions that affect them. According to the National Institute on Drug Abuse (NIDA):

Drug users and their sex partners must be treated with dignity and respect and with sensitivity to cultural, racial/ethnic, and gender characteristics. Successful engagement of at-risk populations in interventions requires that they recognize that concern for them is genuine and that they are seen as capable of undertaking behavioural change. Outreach approaches must be socially and culturally appropriate.”²⁵



This same is true for members of other at-risk populations.

A social assessment conducted during the planning phase can be used to learn about the community's perceived and actual needs. Engaging community members from the population of interest and asking them to identify their strengths, resources and capacities can occur through key informant interviews, focus groups and other methods of engagement.

Working with the leaders of vulnerable communities can provide access to those who wish to remain hidden. These leaders are described in the international literature as “gatekeepers”—and can include community workers, pimps, sex work establishment and bathhouse staff, taxi drivers, shop owners, and drug dealers. “Gatekeepers” can facilitate or impede access to the community.

Gatekeepers can serve both legitimate and dubious purposes. They may be protecting vulnerable people, legitimising some people to speak for everyone, protecting agency or professional “turf,” and defining the relationship between a program and community members.²⁶ Gatekeepers can also block access to outreach programming for well-intentioned reasons, such as a desire to protect community members from stigmatization, intrusion, harm, or to protect organization “turf” or a fear of a loss of control or income. Regardless of the reasons, they need to be included in the planning of outreach interventions.

The use of peers as outreach workers can also be a means of engaging the community. However, despite the belief that using peers is an effective approach, vulnerable people do not automatically trust each other—some people may feel more comfortable with workers not from the community.²⁵ Sex workers can be in competition with each other and shame or secrecy might stop some people from being open with other community members.

There are many other opportunities to involve vulnerable populations. In the planning and implementation stages, they can participate in situational assessments and client satisfaction exercises, or take on roles as researchers, program ambassadors, peer workers, volunteers, and members of advisory and governance bodies.²³ They can also play a role in program reviews and evaluations.

Unfortunately, some providers feel uncertain about how to involve clients in program decisions, especially sex workers and IDUs.²⁷ Engaging them can be challenging, but many programs have found practical ways to work with vulnerable communities.



STEP 2: DESIGN YOUR OUTREACH PROGRAM

The literature on outreach to vulnerable populations offers a range of models, many of which are difficult to distinguish from one another. These include the Indigenous Leader Outreach Model, Community Health Outreach Worker Model, Assertive Outreach, Community-Based Outreach Model, Outreach in Natural Settings Model, and the PRECEDE-Based Outreach Model.^{24,26,28,29}

Rather than defining each of these models, this section will focus on the importance of developing a conceptual framework and some key issues to consider when designing your own outreach program. This section will outline some of the common challenges program planners encounter, as well as operational issues that must be considered.

2.1 DEVELOP A CONCEPTUAL FRAMEWORK AND DEFINE YOUR PROGRAM

An effective outreach program can clearly describe a path from the first investment to the achievement of final results, explaining the steps along the way. Before outreach programs can identify their approaches and activities, however, they must clearly identify their goals and objectives, i.e. what they are trying to accomplish through these activities. If a program does not describe in detail what it is trying to achieve and how it will get there, it will be difficult to know if it ever reaches its objectives.

A **logic model** can be an effective tool to describe the path for new or existing programs. It also offers a means to engage staff, partners, and clients in a collaborative partnership. See Appendix H for more information about logic models.

Logic models are effective because they:

- Provide a simple visual presentation of the program logic (i.e., how it is supposed to work in order to achieve its expected results and make a positive difference in people's lives),
- Provide a "road map" linking programming activities, the people it will reach, and the expected results,
- Facilitate planning, communication and a shared understanding of the program,
- Identify outputs and results, and the indicators to measure them, and
- Identify both programming and evaluation issues.³⁰

Partnerships often start as small initiatives that grow over time, adding new partners and programs. They are frequently driven by a single agency or a couple of individuals who strongly believe in the benefits of partnerships and collaboration, and are willing to invest time and resources to create them.

When designing your outreach program it is important to identify potential partners and to work collaboratively. Research demonstrates the importance of partnerships with other agencies "...to share information, coordinate activities and address multiple needs that clients may have."³¹ It also demonstrates that "... partnerships have the potential to create and identify new and better ways of thinking about health issues."³¹



By engaging communities, organizations can go beyond inter-agency arrangements to create synergy. Collaboration with community based organizations is most successful if there is a sharing of goals, responsibilities and resources.³²

Evidence suggests that partnerships usually develop incrementally and they need leadership.³³

Partners should collaborate and work together. Without this focus, partnerships remain a collection of independent agencies coordinating their discrete activities, but never coming together to jointly develop and deliver interventions. Examples include working together on a funding proposal, collaborating on existing activities, measuring partnership performance, or conducting joint research. See section 3.2 for more information about collaboration and integration of services.

Partnerships can only succeed if partners are willing to give up some of their autonomy to work together on shared goals.^{31,34}

Common issues that program planners encounter when designing outreach programs arise from the need to:

- Balance harm reduction principles and health promotion,
- Balance broad coverage (population focus) and individual needs,
- Reduce imminent harm while also promoting longer-term wellness,
- Reduce the risks and vulnerabilities facing individuals while acknowledging the group norms of the vulnerable population,
- Decide whether to offer stand-alone interventions or to integrate them with larger cohesive programs,
- Determine whether to offer outreach in both “open” and “closed” settings,
- Decide whether to use professional outreach staff or community peer workers or a combination of both,
- Determine whether services should be provided to individuals in their natural settings and/or mobilizing them to access conventional (fixed-site) services, and
- Determine whether the focus of the program should be on a specific population or a particular disease.

See Appendix I for more information related to these and other common issues program planners encounter when designing their outreach programs.



Building a **culture that measures and manages performance** is a logical extension of the logic model and encourages planners to become less focussed on activities and more focussed on results.

When designing your program, it is important to create a culture that supports performance measurement. Often, performance measurement is limited by low agency capacity, a lack of time and resources, and focusing solely on 'what we do'. This is compounded by a lack of analysis of the data collected, a lack of integration into the planning process, and an agenda driven by reporting requirements from funding bodies rather than by self-reflection and improvement.

It is useful to develop measurable indicators for each objective. Measurable indicators are quantifiable measurements that are developed for each objective ahead of time and are used to determine whether progress is being made towards the program's long term goals.³⁶

For example, how will you know if:

- The program is structured in the best way to meet the needs of vulnerable populations?
- Vulnerable populations are being reached?
- Partner agencies are developing the capacity to better serve vulnerable populations?
- The behaviours and situations of vulnerable populations are changing?
- The targeted population is becoming healthier?

When designing an outreach program, it is also important to identify specific times to measure progress. Evaluation monitoring should be done at regular intervals to make sure the program is on track. From an operational perspective, this involves ensuring processes are in place to collect data monthly, quarterly and annually, with a commitment to review the information in a timely manner and develop strategies for improvement.

To support evaluation efforts, staff and partners must be trained to collect, analyze and use data or have access to people who can do this type of work. See Step 4 for more information about measuring results.



2.2 CONSIDER ETHICAL, LEGAL AND RISK MANAGEMENT ISSUES

Outreach programs frequently encounter ethical and legal issues arising from the lives of vulnerable clients who can be marginalized, stigmatized, ill, addicted, and affected by crime and violence. These issues, while challenging, can be guided by general ethical principles and specific codes of conduct.

Nine Circles Community Health Centre (NCCHC) in Winnipeg, Manitoba uses seven guiding ethical principles to conduct their outreach.

Nine Circles Community Health Centre's (NCCHC) Guiding Ethical Principles

Respect for Human Dignity: *This principle aspires to protect the multiple and interdependent interests of the person, from bodily to psychological to cultural integrity.*

Respect for Free & Informed Consent: *Respect for persons involves respecting the exercise of individual consent, which translates into the dialogue, process, rights, duties and requirements for free and informed consent of clients.*

Respect for Vulnerable Persons: *Particular ethical obligations exist for people who have diminished competence and/or decision-making capacity, that result in vulnerability. Particular vulnerable populations might be children, people with mental or physical disabilities, incarcerated people.*

Respect for Privacy & Confidentiality: *Standards of privacy and confidentiality protect the access, control, and dissemination of personal information. These standards help to protect the mental or psychological integrity of clients.*

Respect for Justice and Inclusiveness: *This principle implies that no segment of the population should be unfairly burdened with harms. It imposes duties neither to neglect nor discriminate against individuals or groups who may benefit from contact with the Outreach team.*

Minimizing Harm: *Clients must not be subjected to unnecessary risks of harm through contact with the Outreach Team.*

Maximizing Benefit: *Contact with the Outreach Team is intended to benefit the client.*

Nine Circles Community Health Centre. Outreach team training and resource manual (a work in progress). Winnipeg, Manitoba, Canada: Nine Circles Community Health Centre; 2008. p. 71. Unpublished.



Ethical issues are often more challenging than legal ones because the answers are less clear and two agencies or workers can reach very different answers to the same questions. When dealing with the ethics surrounding clients' behaviours, as with any ethical dilemma, there is a need to balance competing values (e.g., confidentiality and disclosure). For example:

- Should a program protect vulnerable sexual partners of clients known to have HIV or HCV?
- Should clients who are violent towards others, including other clients, be served by a program?
- Should outreach agencies assist the police in finding clients or informing them of planned crimes?
- How assertive should outreach staff be with clients who need but refuse treatment or support?

In addition to giving guidance on ethical and professional issues, guidelines underline key principles such as the importance of: treating others as you would want to be treated; doing no harm; and being respectful, competent and compassionate.

See the box below as an example of the guideline that has been adopted by the National Health Care for the Homeless Council.

Professional and Ethical Guidelines for Outreach Workers

The overriding philosophy of these guidelines is to treat others as you would want to be treated. This applies not only to interactions with clients, but with coworkers, supervisors, and staff from other agencies, policy-makers, etc. At the very least, do no harm. It is expected that outreach workers will consistently treat others in a respectful manner and provide competent and compassionate care to clients... It is prudent for workers to anticipate and identify ethical dilemmas that arise in outreach and to discuss these issues with supervisors and peers. Some of the guidelines are intended to prompt such discussions with hopes that adherence to the HCH philosophy of care and practice within proper boundaries will result.

National Health Care for the Homeless Council. Professional and ethical guidelines for HCH outreach workers [Online]. Nashville, TN: National Health Care for the Homeless Council; n.d. [cited 2010 Mar 1]. Available from: URL:<http://www.nhchc.org/Curriculum/module2/module2A/H3ProfessionalandEthicalGuidelinesforHCHOutreachWorkers.pdf>

With regards to **legal issues** in Canada, it is advised that outreach programs follow the law, even laws that may conflict with ethical principles. To do otherwise, may endanger the program's ability to provide services.

Relationships between outreach staff and **police** authorities can be complex and shifting³⁷ due to competing ethical frameworks: e.g. upholding the law versus promoting the health and wellness of vulnerable people, some of whom might be engaged in illegal or anti-social activities. In order to overcome these challenges, outreach programs need to understand the wide discretionary powers of the police and negotiate with them for a "space" to operate within those parameters.

Law enforcement and outreach staff work well together when there is mutual respect and understanding.



If properly informed, police can promote outreach to potential clients.³² Outreach/police partnerships that worked well include a positive working rapport with clear lines of communication.³² Establishing the legitimacy of outreach in the eyes of the police is also important. This can be accomplished by “...law enforcement executives serving as champions for these efforts”³⁷ and sending clear messages to their officers that outreach is a part of the team. Ideally, an introduction to the work of health and social service agencies should be included in police training.

The development of a good working relationship with the police may create new challenges with the clients of vulnerable population outreach programs, many of whom are suspicious of the police. Letting clients know about the nature of the working relationship, the roles of each partner, and what information is shared between police and outreach agencies helps make the arrangement transparent.³⁸

Some researchers recommend taking a fairly straightforward position on information-sharing with the police—the police should share information with outreach programs, where appropriate, but outreach programs will never share information on program clients with the police.³⁷

HIV/STBBI outreach workers should be aware that the laws governing the actions of frontline workers on disclosing HIV status of clients are not entirely clear. Also, the ‘criminalization’ of HIV/AIDS has implications for agencies and their staff.

See Appendix J for more information about the duty of workers to prevent serious, foreseeable and imminent harm to others (also known as the “Duty to Warn”).

Managing risk is an important component of outreach program management. This is because outreach involves interaction with those living on the margins of society who:

- May be involved in illegal or socially unacceptable behaviour;
- Are vulnerable to stigma and discrimination;
- May be prone to trauma and emergencies, including violence;
- May have communicable diseases which may be accidentally transmitted; and,
- Place huge stresses on the physical, mental, and emotional safety and health of staff.

Those familiar with outreach agree that outreach involves risks for staff, clients, implementing agencies, funders, and the wider community. These include risks to the safety of individuals and political risks to an agency or funder. They may involve crossing a blurred line between activities that are legal and ethical and those that are not which can adversely affect an agency’s reputation. As with all risks, there is an element of unpredictability. While there is a considerable amount written on protecting the well-being of staff and clients, there is very little on the risks to outreach programs as a whole and how best to manage them.

Risk management ensures that programs continue and the interests of clients, staff, agency and partners, funders, and the broader community are protected.

A Treasury Board policy on Risk Management outlines four activities for managing risks. Although these



were written for government departments, they have broader applicability:

- Identifying the risks
- Taking steps to minimise these risks and their costs
- Limiting damage as it is occurring
- Taking corrective action after an incident³⁹

A risk management plan for outreach programs should ideally be part of a larger plan for the organization and include components, such as:

- Identification of the risks facing an outreach program and ranking them in terms of likelihood and seriousness; the steps to reduce the likelihood of the risks occurring; and the responses during and after the incident (including identifying who is responsible for managing the response).
- Personal safety guidelines and training for staff (e.g., therapeutic crisis intervention).
- Occupational health and safety policies and procedures, including needle stick injuries. This might include a policy on the use of post-exposure prophylaxis (PEP).
- Incident reporting procedures, including assaults by clients on staff and other clients; verbal, physical, and sexual abuse; contact with the police; and, accidents and illness on the job.
- Critical incident debriefing for staff following crises. Staff access to employee assistance programs (EAP) to promote and preserve their physical and mental well-being.
- Development of a supportive working environment in which managers and staff support each other by building resilience to external stresses and shocks.
- Communication plans for possible incidents, including dealing with the media.

Organizations interested in using peer workers are advised to consider the pros and cons before proceeding. This will provide the opportunity to determine if using peers is appropriate for their situation and to identify potential risks and suitable roles and support requirements if they choose to proceed.⁴⁰

2.3 DEVELOP POLICIES, PROCEDURES AND GUIDELINES

A policy is typically described as a principle or rule to guide decisions and achieve rational outcome(s). The term is not normally used to denote what is actually done; this is normally referred to as either a procedure or protocol. Whereas a policy will contain the “what” and the “why,” procedures or protocols contain the “what,” the “how,” the “where,” and the “when”⁴¹— they outline how you will carry out the policies you set.

A strong understanding of what you want to do (goals and objectives) and how exactly you will do it (outreach approaches) are important to know before you start developing policies, procedures and guidelines.



Outreach programs should develop policies to address the following:

- 1. Confidentiality**, including informed consent procedures for information sharing;
- 2. Cultural competence** to include community representation and cultural sensitivity;
- 3. Data security** to ensure that sensitive information is protected;
- 4. Linkage of services**, particularly to HIV testing and care for those who are living with HIV/AIDS. Assess whether referrals were made and completed;
- 5. Personnel policies**, particularly a code of conduct covering staff–client interactions
- 6. Safety of staff and clients**, including plans for medical and psychological emergencies
- 7. Selection of target populations**, including criteria which justifies their selection;
- 8. Volunteers**, including clarity on their coverage by liability insurance, workers' compensation, training standards, codes of conduct, and confidentiality agreements.²²

Policies, procedures and operational guidelines will also be needed to address program specific issues, such as safe injection/inhalation, case management, as well as testing and counselling. Approaches to be used as codes of conduct include staff/client safety, crisis management, working with minors, cold weather work, scheduling, documentation etc. should also be considered in policies, procedures and guidelines.

2.4 CONSIDER STAFFING AND STAFF DEVELOPMENT NEEDS

Developing and managing outreach staff involves different approaches, some generic and some particular to outreach. Generic approaches include building a shared understanding of the program's goals, involving staff in planning and managing their work, respecting staff expertise, and creating opportunities for professional growth. The issues particular to outreach include building staff resilience and retention⁴³ (e.g., avoiding burn-out), and dealing with ethical and legal issues.

An increasing number of studies in the human service field suggest that organizational climate (i.e. attitudes shared by employees about their work environment) is a primary predictor of positive service outcomes and a significant predictor of service quality for clients of human service agencies.⁴³ See Appendix K for a list of organizational factors that have been found to support positive work environments, which in turn, enable successful recruitment and retention of staff.

Recruiting staff tends to be more fluid for outreach workers than with other helping professions because of the lack of training programs and accreditation. Street outreach positions are often entry level jobs, and this can create an impression that they are at the bottom of an agency's hierarchy. In Canada, only Quebec has made efforts to professionalize outreach workers.

Outreach workers must be independent, flexible, and innovative self-starters. The qualifications of workers will vary based on organizational and service needs. See Appendix L for more information about outreach worker qualifications.



There is no evidence to support the notion that a specific personality type is more effective than another at doing outreach. In fact programs can benefit from a range of personalities, employing them creatively to deal with challenging clients.²⁶

It is interesting to note that many of the very characteristics that make someone good at outreach also make them less inclined to complete paperwork or fit into the corporate cultures of larger agencies.⁴⁴

Whether a program will employ peer workers or use volunteers, such as natural helpers, also needs to be considered. This will depend on what the outreach program tries to achieve and the specific skill set needed to meet its objectives. It is also important to consider the contribution of the different types of workers as well as the challenges or demands on management. Reviews of peer work, for instance, have shown it to be an effective approach and peer workers can access hidden and distrustful communities and build their trust in the program. But the use of peers also poses challenges in terms of supervision, turnover, liability and public perception (see appendix I for more detailed discussion). There is also a tendency to view volunteers as “free” resources. In fact, volunteers can be quite expensive in terms of training and supervision, and the amount of paid staff time required to ensure their motivation and quality control. Most organizations that successfully use volunteers do so because they view volunteers as a valuable asset to programming, worthy of attention and investment, and not a way to reduce costs.

Training must be provided to develop workers and keep them well informed and supported^{45, 46}. The lack of formal outreach training programs means that most learning will likely occur in-house, either formally or through on-the-job mentoring.

Outreach training programs are based on an “informal blend of logic and practical experience” and incorporate the stages of change theory. Ashery outlines the following requirements for outreach worker training:

- Training must ensure credible and competent field delivery,
- Outreach workers need to accept, internalize and incorporate theory driven elements of intervention in natural and credible interpersonal interactions with clients, and
- Evaluation and feedback are crucial to ensure success and replicability of a successful street (outreach) intervention.⁴⁷



Another approach to developing and managing staff is defining the competencies of outreach workers. The Center for HIV, Hepatitis C, and Addictions Training and Technology (CHATT) developed the *Outreach Competencies—Minimum Standards for Conducting Street Outreach for Hard-to-Reach Populations*⁴⁸ and identified the following competencies for outreach workers:

COMPETENCY 1:	Understand outreach, including research protocols and behavioural science.
COMPETENCY 2:	Understand chemical dependency models, including substance use versus abuse, pharmacology, and treatment regimes.
COMPETENCY 3:	Understand health issues, specifically HIV, HCV, and TB, in the context of drug use.
COMPETENCY 4:	Engagement, through recruitment, cultural sensitivity, safety, and communication.
COMPETENCY 5:	Interventions, including health information and demonstration, risk assessment and reduction, prevention, post-test counselling, crisis intervention, confidentiality, laws, and regulations.
COMPETENCY 6:	Client support, including service referrals.
COMPETENCY 7:	Supporting each other, specifically burnout prevention and relapse prevention (important when workers may be past or current drug users).

Required knowledge also includes things like agency mission, statutory obligations (e.g., reporting child abuse), infectious disease transmission and prevention, addictions and mental health, codes of conduct, as well as knowledge of the client community and other service providers. Other skills related to the specifics of the outreach program should be identified by the organization and may include such things as: condom use and safer injection/inhalation demonstrations, pre- and post-test counselling, reporting, and personal and client safety.

Programs have used regular staff meetings and office time, as well providing access to mental health professionals, as ways of addressing specific traumas and ongoing stress. Creating a culture in which frontline staff are recognized and validated is important to keep staff motivated. See Appendix M for information about one organization’s approach to supporting their outreach staff.



Staff burnout among health service providers "...refers to a syndrome of physical and emotional exhaustion involving the development of negative job attitudes, a poor professional self-concept, and a loss of empathic concern for clients."⁴⁹ Responsibility for preventing or dealing with burnout rest with both the organization and the individual worker.

Organizational responsibilities include reducing the level of work-related stress, being vigilant for the signs of staff burnout or "compassion fatigue",⁵⁰ and providing support to those who are becoming or who already are burned out. Staff responsibilities for burnout include knowing what it is, recognizing the warning signs in one self and others, and seeking help. This can be summarized as a duty of self-care.⁵¹

Supervision of outreach staff is complicated by their work in small teams away from the agency, often after office hours, and the discretionary powers they need to deal independently with a wide range of situations. Despite this, outreach workers still need to be held accountable for their decisions and behaviour, and require supervision that is formal, structured and regular.

Supervision of outreach workers should include regular individual sessions between the supervisor (usually the program manager) and each member of the staff. These meetings should be supportive and review the individual's performance and, if necessary, the need for improvement or further training. They should also look at the person's relationships with clients, feelings about their work and career plans.⁵²

Given the nature of outreach work, it is essential to have well understood standards of professional behaviour (i.e. codes of conduct), detailed job descriptions and established performance monitoring and discipline processes.



STEP 3: DELIVER THE SERVICES

During the implementation phase you will put into practice the plan described in your program framework which may be based on a logic model. Primarily the services you include will aim to mobilize clients to reduce risk and vulnerability created by inequities and deficits in social determinants. The focus of the outreach activities should be on

- Building relationships with clients,
- Integrating services,
- Mobilizing the community,
- Building capacity, and
- Advocating for those who are unable to advocate for themselves.

3.1 MANAGE THE PROGRAM

Program administration is a broad area that includes developing schedules, managing human resources and finances, using volunteers, managing and collecting data, etc. It is important to note that different programming choices will result in different administrative structures and levels of effort. For example, delivering HIV/STBBI outreach from a van will require policies on driver training and insurance, purchasing fuel, maintenance and repairs, cleaning the vehicle, parking, and stocking it with supplies (and emptying it in the winter as condoms and other supplies cannot be allowed to freeze).

This seems simple but all these tasks together represent a considerable amount of effort. If staff is required to clean and stock an outreach van, this will be time not spent with clients. This might be acceptable to program managers but it needs to be planned and understood from the beginning. Other administrative considerations are required when programs use volunteers, including screening and police checks, training and certification, liability and accident insurance, codes of conduct, scopes of practice, and supervision.

3.2 INTEGRATE SERVICES

Vulnerable communities have complex needs that contribute to overall vulnerability (e.g., homelessness, violence, and addictions) and must be addressed. Given that most agencies and programs do not have the capacity, resources, and mandates to meet all of their clients' needs, it is important to establish links and partnerships with those who come from a range of health, social services, community development and social justice perspectives, and share the same mandate to protect and promote the wellbeing of vulnerable people.

Duplication, fragmentation, and inter-agency competition are recognized by those who work with vulnerable populations as inefficiencies undermining programming. Concerns have been expressed that fragmented service delivery affects accessibility and this adversely affects the health and well being



of vulnerable people.”⁵³

Attempts can be made to address these challenges at the macro (system-wide), meso (inter-agency), and micro (client) levels. For most agencies, the easiest response is to coordinate street-level activities and share information. Unfortunately, such initiatives only work around the margins of systemic problems rather than envisaging a different way of working together to benefit the communities served.

At the micro (client) level, HIV/STBBI program staff know the frustration of not being able to help clients access needed services unrelated to their mandate (e.g., housing) or to coordinate the delivery of these services. One solution appears to be the difficult work of building and sustaining strong inter-agency partnerships that focus on providing clients with a single access point to services and a seamless referral process.⁵⁴⁻⁵⁶ Developing these relationships means determining how decisions should be made and resources allocated, as well as overcoming the practical challenges posed by different mandates, work cultures, and staffing practices (e.g., professional qualifications, pay levels, and employment terms).³³

Programs have experimented with both formal and informal approaches to partnerships. In the case of Hamilton’s Public Health Department, both approaches are used.⁵⁵ Streets Ahead, a best practice guide based on six programs in the UK, defines both formal and informal partnerships and also suggests the use of both. It also promotes the idea of the case conference as a way of coordinating inter-agency service delivery to individuals.³¹

Strong partnerships and collaborative programming could solve several outreach programming challenges including:

- Inefficiencies created by fragmentation, duplication, and inter-agency competition,
- Client confusion and service access barriers, and
- Lost opportunities by agencies with similar foci and goals to better serve their shared clients.

While it is unlikely that an HIV/STBBI outreach program would have the police as a formal partner, the police can play an important role in the program’s effectiveness. At a minimum, outreach programs need to recognize the impact of enforcement on their programming and be able to negotiate a “space” to operate. In some cases, the police can play an active role in referring clients to the program and providing information to potential clients. Positive relationships with the police appear to be based upon mutual respect for each other’s roles, communication, and positive rapport.³¹

It is also worth mentioning the challenges in working with agencies that have different views on issues like sexuality and addictions. The best solution is to be respectful and honest; to try to understand the other person’s ethical perspective and to build relationships based on what



each is best suited to provide. See Appendix N for a complete description of partnership synergy.

Another challenging outreach programming issue is the **referral process**. Many outreach practitioners believe that measuring referrals' success is difficult because of confidentiality and privacy issues, uncertain inter-agency access, little time for follow-up, unpredictable clients, and the limits of existing partnerships. In addition, when outreach is offered by small community organizations, this challenge is magnified as their links to broader programming are often not solid. Yet, it is also clear that this challenge must be faced if outreach programming is to deal effectively with their clients' needs. A number of HIV/STBBI programming frameworks propose referrals as a means of introducing clients to more focussed health services and meeting needs that fall outside an HIV/STBBI program's mandate.

Developing partnerships is an important part of building an effective referral process. A collaborative inter-agency referral network should be able to:

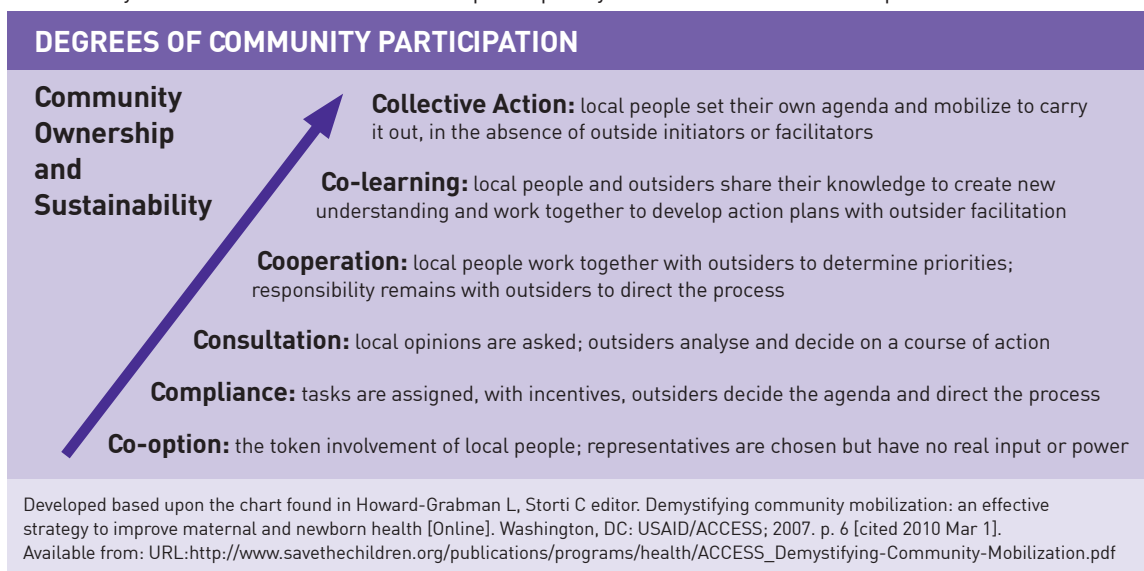
- Link clients to a needed service in a partner agency,
- Confirm with the partner agency that the referral was successfully completed, and
- Confirm with the client that the referred service was the one that was needed and that they were satisfied with the services they received.

3.3 MOBILIZE THE COMMUNITY

Community mobilization is a dynamic process that involves planned actions to reach, influence, enable, and involve key segments of the community. Collectively they can create an environment that will effect positive behaviour and bring about desired social change.⁵⁷

More simply, it can be seen as the process of building community awareness on an issue in order to encourage community action in pursuit of positive change. When applied to health issues, it can also be:

...a capacity building process through which community members, groups, or organizations plan, carry out and evaluate activities on a participatory and sustained basis to improve their health and



Community mobilization is about empowering communities to develop and implement their own solutions, through structures and methods they control by:

- Building upon existing social networks,
- Shifting decision-making power,
- Defining needs through community-based processes,
- Addressing underlying vulnerabilities, and
- Motivating communities to be their own advocates.⁵⁹

Community mobilization also has the advantage of “...increasing local acceptance and commitment, accessing knowledge and expertise (particularly around local community issues), gaining additional resources, and increasing community capacity.”⁶⁰

Access to social support — sometimes referred to as “social capital” — is vital to reducing vulnerability of marginalized or disempowered groups. In nearly all countries where the HIV epidemic has been reversed, grassroots community mobilization was at the heart of the national HIV response. However, not all countries have a tradition of community engagement and empowerment.⁶¹

Across Canada, outreach programs have involved community members in the work affecting them, including them in planning and review exercises, and inviting them to join advisory bodies.

Community members can gather data, recruit clients and market outreach programs to their networks. In addition to these engagement activities, vulnerable communities should be encouraged to organise themselves, advocate on their own behalf and participate fully in the broader policy discussions affecting them.

3.5 BUILD CAPACITY AND ADVOCATE

Capacity building generally refers to the skills, infrastructure, and resources of organizations and communities necessary to effect and maintain behaviour change, thus reducing the level of risk for disease, disability, and injury.⁶²

Capacity building needs to be carefully planned, implemented, and measured. A simple strategy identifies and prioritizes capacity needs and develops a plan to meet them by recognizing the skills, knowledge, and processes relevant to the delivery of a specific program. Training, coaching and sharing best practices can



help build capacity.

Advocacy is "... the application of information and resources (including finances, effort, and votes) to effect systemic changes that shape the way people in a community live."⁶³ Public health advocacy could include activities that convince people to make healthier choices; raise funds to promote an agenda; build coalitions of vulnerable communities, stakeholders and sympathetic community members; encourage decision makers to engage with an issue requiring legislative or policy changes and public funding; and, shift public and political attention towards a specific issue through the use of the media, public events, and letter writing campaigns. Like capacity building, advocacy is an activity best done in partnership with others. Also, if an outreach program is committed to community engagement, community members should be a major player in the advocacy done on their behalf. Those who work with the most marginalized and disempowered citizens must consider their responsibility to go beyond the provision of care and service access and to include in their role one of political advocacy to reduce vulnerability.⁶³

Advocacy can happen at many levels. It can be directed at clients when workers encourage them to make healthier choices. It can be directed at service providers, when workers try to refer clients to services. Finally, it can happen at a system level, when outreach programs try to bring about environmental change in order to promote both their work and the well-being of their clients. This last form of advocacy is often a political act focussing on societal inequities and injustices.

Providing services to vulnerable populations can be controversial and open to misunderstanding and attack. Problematic client behaviours, such as discarding needles, cruising in parks, and sex work on residential streets can cause difficulties for programs. Media and public attention can quickly shift to the question of whether outreach programming enables "bad behaviour".

The inability of programs and agencies to explain the importance of their work and their role in protecting the health of everyone can result in programs being cancelled or proscribed (e.g., "safe zones", restrictive needle exchanges). Advocacy can play a role in reducing these risks by building support for programming, and responding to incidents and criticism.

It is clear that successful programs resist the temptation to "go around" an individual or an organization that is reluctant or critical. Certainly, no individual or small group should have veto power over community planning for needed services. On the other hand, experienced program planners strongly suggest that



human barriers be taken into account and not dismissed with the hope that individuals will come around.⁴⁴

It has been argued that effective health policy advocacy at a national level is based upon:

- Complete and credible data,
- Coordinated action by participants in an advocacy campaign,
- Specific advocacy goals,
- Coordinated action at different levels of government and in different regions, and
- Public appeal — focus on stories with human appeal and not the data.⁶⁴

Obviously, not all of these initiatives are possible for local advocacy efforts, although they are instructive, and even small programs might benefit from provincial-level advocacy. Other points for consideration include how best to frame an issue, understanding the interests and ideologies of decision makers, building the capacity of advocacy groups, exploiting unexpected opportunities, and building coalitions.⁶⁴

A final point of caution is that some organizations, by their public nature or the conditions of their public funding arrangements, may be limited in their ability to engage in overt advocacy activities or at least to spend funds on advocacy related activities. There may also be a political price to pay for organizations that publicly pursue agendas running counter to those of a funding body. While there may be ways around such restrictions and risks, it is important to understand potential implications.



STEP 4: MEASURE THE RESULTS

The measurement of program performance is the final step in the process of developing and delivering a program. It is done to:

- Determine the extent to which a program has rolled out as planned (process evaluation),
- Look at changes in pre-disposing, enabling or reinforcing factors (impact evaluation), and
- Look at whether the intervention(s) have affected health and quality of life indicators.

...or more simply to determine if:

- The work that is being done is the most effective way to deliver the program, and
- Whether the program is achieving its expected results and making, or associated with, a positive difference.

A group of service providers in British Columbia identified the need for simple and practical program evaluation. This project was undertaken in recognition of the fact that evaluation is “largely perceived as a reporting exercise rather than an activity that benefits the organization”.⁶⁵ Evaluation is often done only because it is a funding requirement and reporting to the funder and evaluation is often seen as synonymous. The project suggests the following to ensure success:

- Identify evaluation as a budgeted item and dedicate resources.
- Increase capacity within organizations (including offering training and support from an evaluation consultant).
- Establish clear, realistic guidelines and expectations, including better reporting forms.
- Develop standardized and flexible data collection tools.
- Create opportunities to share best practices, and develop “evaluation champions.”
- Nurture a culture that embeds evaluation into the planning and delivery of the program and promotes the use of evidence and best practices.⁶⁵



4.1 DEVELOP A PERFORMANCE MEASUREMENT FRAMEWORK

A Performance Measurement Framework can be used to both monitor on-going activities and ultimately evaluate program impact. When developing a performance measurement framework, one must decide what information will be needed to measure program performance and where that information will come from.

Generally, an outreach program will want to evaluate the following:

- Did the program do what it said it would, in a timely and cost-effective manner?
- Did the program reach a significant proportion of targeted vulnerable populations?
- Did the program contribute to the development of positive behaviours and situations (or the elimination of negative behaviours and situations)?
- Did these changes in behaviours and situations contribute to improved health and well-being?

To develop a performance measurement framework, it is best to refer back to the conceptual model to find out what you set out to achieve. When developing your evaluation framework, remember that evaluating process is equally as important as evaluating outcomes.

Performance Measurement

Performance measurement is extensively and increasingly used to measure the performance of government programs. In comparison with evaluation, which usually undertakes special one-time measures and extensive analysis of the data gathered, performance measurement is characterized by regular and often more straightforward measurement of aspects of a program's performance. Performance indicators are used to track performance and feedback information to managers and staff. They can form the basis for reports on what has been achieved by the program.

Mayne J. Addressing attribution through contribution analysis: using performance measures sensibly. A discussion paper [Online]. Ottawa, ON: Office of the Auditor General of Canada; 1999, pp. 3-4 [cited 2010 Mar 1]. Available from: URL:http://www.oag-bvg.gc.ca/internet/docs/99dp1_e.pdf

Generally, programs can easily generate data on its activities. However, it is more complicated to measure changes in behaviours or health status over time. Generating this type of data takes significant resources, time and skill. It is for these reasons that programs tend to rely on external groups like the Public Health Agency of Canada (PHAC), provincial and territorial ministries of health, and regional health departments to provide information on long-term behavioural and health outcomes.



4.2 MONITOR PROGRESS

A part of any successful program is having the ability to know when you have reached your goal or at least made progress toward achieving your objectives and knowing when you have strayed off course. Regular monitoring allows for the identification of program successes and challenges along the way.

The time to develop monitoring criteria is early in the planning process (Step 2) where measurable indicators are identified for each objective.

4.3 SHARE RESULTS AND CELEBRATE

The advantages of sharing results and celebrating with others include being able to:

- Keep communication channels open
- Identify what worked well and what didn't work well early in the process
- Maintain momentum
- Identify if additional resources are required
- Contribute to the global understanding of what works
- Build morale
- Recognize the efforts of those involved in the program



CONCLUSION

Outreach activities have the potential to effect positive changes in the lives of underserved and vulnerable populations as a means of reducing and overcoming barriers to health.

The conceptual model presented in this Guide proposes a systematic approach to planning, delivering and evaluating outreach activities while acknowledging that outreach activities should be tailored to meet the specific needs of the population, disease or location.



REFERENCES

- 1 Elwood E, et al. To hang in the 'hood: description and analysis of outreach activities. *Journal of Psychoactive Drugs* 1995;27(3):249-59.
- 2 Keller L. Population-based public health interventions: practice-based and evidence-supported (Part I). *Public Health Nursing*, 2004;21(5):456.
- 3 Khandor E, Mason K. The street health report [Online]. 2007. Available from: <http://www.streethealth.ca/Downloads/SHReport2007.pdf>
- 4 CIPI. Improving the health of Canadians: mental health and homelessness—summary report [Online] 2007. Available from: http://secure.cihi.ca/cihiweb/en/downloads/mental_health_summary_aug22_2007_e.pdf
- 5 McKay, A. Prevention of sexually transmitted infections in different populations: A review of behaviourally effective and cost-effective interventions. *Canadian Journal of Human Sexuality*. 2000;9(2):95-120.
- 6 Public Health Agency of Canada. Populations at risk [Online document]. 2007. Available from: <http://www.phac-aspc.gc.ca/aids-sida/populations-eng.php>.
- 7 Gibson DR, McCusker J, Chesney M. Effectiveness of psychosocial interventions in preventing HIV risk behaviour in injecting drug users. *AIDS*. 1998;12(8):919-929.
- 8 Wright N, Tompkins C. A review of the evidence for the effectiveness of primary prevention interventions for Hepatitis C among injecting drug users. *Harm Reduction Journal* 2006;3:27-35.
- 9 Giger JN, Davidhizar R. Promoting culturally appropriate interventions among vulnerable populations. *Annual Review of Nursing Research* 2007;25:293-316.
- 10 Harling G, Wood R, Beck EJ. Efficiency of interventions in HIV infection, 1994-2004. *Disease Management & Health Outcomes* 2005;13(6):371-394.
- 11 Peragallo N, Gonzalez RM. Nursing research and the prevention of infectious diseases among vulnerable populations. *Annual Review of Nursing Research* 2007;25:83-117.
- 12 Sangani P, Rutherford G, Wilkinson D. Population-based interventions for reducing sexually transmitted infections, including HIV infection (Review). *Cochrane Database of Systematic Reviews*, 2004;3:Art. No: CD001220.
- 13 World Health Organization. Evidence for action: effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users [Online]. Geneva: World Health Organization; 2004. Available from: <http://www.who.int/hiv/pub/idu/idu/en/>
- 14 Johnson WD et al. Behavioral interventions to reduce risk for sexual transmission of HIV among men who have sex with men. *Cochrane Database of Systematic Reviews*, 2008;3:Art. No: CD001230.
- 15 Harling G, Wood R, Beck EJ. Efficiency of interventions in HIV infection, 1994-2004. *Disease Management & Health Outcomes* 2005;13(6):371-394.
- 16 World Health Organization. Evidence for action: effectiveness of community-based outreach in preventing HIV/AIDS among Injecting drug users [Online]. Geneva: World Health Organization; 2004. Available from: <http://www.who.int/hiv/pub/idu/idu/en/>
- 17 Mykhalovskiy, E et al. 'Beyond buzzwords: toward a community based model of the integration of HIV treatment and intervention' *AIDS Care* 2009;; 21(1): 25-30.
- 18 National Collaborating Centre for Infectious Diseases. HIV/STI knowledge synthesis and exchange forum—building and exchanging knowledge for reaching vulnerable populations: summary report on proceedings and discussion; 2008.



- 19 AIDS Projects Management Group. Guide to starting and managing needle and syringe programs [Online] 2007. Available from: <http://www.unodc.org/documents/hiv-aids/NSP-GUIDE-WHO-UNODC.pdf>.
- 20 Health Communication Unit, Centre for Health Promotion. Comprehensive workplace health promotion catalogue of situational assessment tools: glossary. Toronto, ON: University of Toronto; [Online] 2006 in Population Health Assessment and Surveillance Protocol (PHAS) of the Ontario Public Health Standards. Available from: http://www.health.gov.on.ca/english/providers/program/pubhealth/oph_standards/ophs/progstds/protocols/population_health_assessment.pdf
- 21 Region of Waterloo. Evidence and Practice-based Planning Framework. [Online] 2006. Available from: [http://www.region.waterloo.on.ca/WEB/health.nsf/DocID/FD80C0D143A204F78525761D0061829A/\\$file/EPPF_maindoc.pdf?openelement](http://www.region.waterloo.on.ca/WEB/health.nsf/DocID/FD80C0D143A204F78525761D0061829A/$file/EPPF_maindoc.pdf?openelement)
- 22 Center for Disease Control. Provisional procedural guidance for community-based organizations [Online]. 2008. Available from: http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/pro_guidance/index.htm
- 23 Centre for Disease Control. Outreach strategies training [PowerPoint]. Available from: www.cdc.gov/outreach/resources/OutreachOverviewPresentation.ppt
- 24 The Salisbury Centre for Mental Health. Keys to engagement—briefing 1 [Online]. 2002. Available from: <http://www.scmh.org.uk/pdfs/briefing1.pdf>
- 25 National Institute on Drug Abuse. Principles of HIV prevention in drug using populations [Online]. 2008 Jan 8. URL:<http://www.nida.nih.gov/pohp/principles.html>
- 26 Ford C et al. Key components of a theory-guided HIV prevention model: pre-outreach preparation, community assessment, and a network of key informants. *AIDS Education and Prevention* 2007;19(2):176.
- 27 Homeless Link. Strategic partnership working. Street outreach good practice handbook [Online]. 2009. Available from: <http://handbooks.homeless.org.uk/streetoutreach/positiveservice/strategicpartnership>
- 28 World Health Organization. Evidence for action: Effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users [Online]. Geneva: World Health Organization; 2004. Available from: <http://www.emro.who.int/aiecf/web2.pdf>
- 29 National Institute on Drug Abuse. Community-based outreach manual [Online]. 2000. Available from: <http://www.drugabuse.gov/PDF/CBOM/Manual.pdf>
- 30 Rabinovitch A. Realizing more benefits from logic models: what logic models can learn from benefits realization. Presentation to Canadian evaluation society—National Capital Region Area [Online]. 2007. Available from: http://ncc.evaluationcanada.ca/downloads/presentations/bs_0607/LM_rabinovitch_0607.pdf
- 31 Homeless Link. Streets ahead: Good practice in tackling rough sleeping through street outreach services [Online]. 2008. Available from: www.handbooks.homeless.org.uk
- 32 Sieverding, J., Boyer, C., Siller, J., Gallaread, A., Krone, M. & Chang, Y.J. Youth united through health education: Building capacity through community collaborative intervention to prevent HIV/STD in adolescents residing in high STD prevalent neighbourhoods. *AIDS Education and Prevention* 2005; 17(4): 375-385.
- 33 Lasker RD, Weiss ES. Creating partnership synergy: the critical role of community stakeholders. *Journal of Health & Human Services Administration* 2003; 26(1):30.
- 34 Vaillancourt V. Capacity building: a model for street outreach [Online]. 2003. Available from: <http://www.sharedlearnings.org/resources/capacity/en/CapacityFinalAug28.pdf>
- 35 “Performance indicator” retrieved September 17, 2010 from http://en.wikipedia.org/wiki/Performance_indicator
- 36 The Santa Cruz AIDS Project. Drop-in centre (DIC): An HIV prevention, harm reduction and community health resource center—policies and procedures [Online]. 2004. Available from: <http://www.cdc.gov/outreach/resources/DICPolicyProcedures.rtf>



- ³⁷ Decker HS, et al. Street outreach workers: Best practices and lessons learned. Innovative practices from the Charles E. Shannon Jr. Community Safety Initiative Series [Online]. 2008. Available from: http://www.shannoncsi.neu.edu/ask_the_experts/technical_assistance/resource_guides/documents/Street_Outreach_Resource_Guide.pdf
- ³⁸ Homeless Link. Street outreach good practices handbook [Online]. 2009. Available from: <http://handbooks.homeless.org.uk/streetoutreach>
- ³⁹ Treasury Board of Canada Secretariat. Risk management policy [Online]. 2001. Available from: <http://www.tbs-sct.gc.ca/pol/doc-eng.aspx?id=12253§ion=text#cha2>
- ⁴⁰ B.C. Harm Reduction Strategies and Services. A manual for frontline staff involved with harm reduction strategies and services [Online]. 2009: Annex 7 – Activity 7C. Available from: www.bccdc.ca/NR/rdonlyres/C8829750-9DEC-4AE9-8D00-84DCD0DF0716/0/HRTRAININGMANUALAUG2009withappendices.pdf
- ⁴¹ "Policy" retrieved September 17, 2010 from <http://en.wikipedia.org/wiki/Policy>
- ⁴² Centers for Disease Control and Prevention. Outreach Workers: Burnout and Relapse. PowerPoint presentation. [Online] Available from: http://www.cdc.gov/outreach/resources/Burnout_Relapse.ppt.
- ⁴³ Herbert M. Child welfare project: Creating conditions for good practice [Online]. 2003. Available from: <http://www.cecw-cepb.ca/publications/1020>
- ⁴⁴ Peterson TA, Bucy J. The outreach team. In The street outreach training manual. U.S. Department of Health and Human Services. [Online]. 1993. Available from: http://www.eric.ed.gov/ERICDocs/data/ericdocs2sql/content_storage_01/0000019b/80/13/3d/0a.pdf
- ⁴⁵ French, R., Power, R. and Mitchell, S. 'An evaluation of peer-led STD/HIV prevention work in a public sex environment'. AIDS Care 2000; 12(2): 225-234.
- ⁴⁶ Bonell, C., Strange, V., Allen, E. & Barnett-Page, E. HIV prevention outreach in commercial gay venues in large cities: evaluation findings from London, Health Education Research 2006; 21(4): 452-464.
- ⁴⁷ Ashery, R.S. Nontraditional employees: indigenous outreach workers employed as AIDS educators for street addicts. Journal of community Psychology 1993;[21]:200-209.
- ⁴⁸ Centre for HIV, Hepatitis C, and Addictions training and Technology. Outreach Competencies—Minimum Standards for Conducting Street Outreach for Hard-to-Reach Populations. [Online]. 2009. Available from: <http://www.nattc.org/regcenters/productDocs/2/2009%20updated%20Outreach%20Competencies.pdf>
- ⁴⁹ Jones, JW. A Measure of staff burnout among health professionals. Paper presented at the Annual Convention of the American Psychological Association (88th, Montreal, Quebec, Canada, September 1-5, 1980). From an abstract available at http://www.eric.ed.gov/ERICWebPortal/custom/portlets/recordDetails/detailmini.jsp?_nfpb=true&_ERICExtSearch_SearchValue_0=ED201924&ERICExtSearch_SearchType_0=no&accno=ED201924.
- ⁵⁰ Edwards R. Compassion fatigue: when listening hurts. American Psychological Association, APA On-Line, 2009. Available from: <http://www.apa.org/monitor/sep95/care.html>
- ⁵¹ Canadian Nurses Association. Code of ethics for registered nurses [Online]. 2008. Available from: http://www.cna-aiic.ca/CNA/documents/pdf/publications/Code_of_Ethics_2008_e.pdf
- ⁵² AIDS Projects Management Group. Guide to starting and managing needle and syringe programs [Online]. 2007. Available from: <http://www.unodc.org/documents/hiv-aids/NSP-GUIDE-WHO-UNODC.pdf>
- ⁵³ Rosenheck RA, Resnick SG, Morrissey JP. Closing service system gaps for homeless clients with a dual diagnosis: integrated teams and interagency cooperation. Journal of Mental Health Policy and Economics 2003;6:77.
- ⁵⁴ Lasker RD. Medicine and public health: the power of collaboration. New York (NY): New York Academy of Medicine 1997:55-67.



- ⁵⁵ Mental Health Outreach Team. An unpublished slideshow from the Family Services Division, Public Health Services, City of Hamilton. Hamilton, Ontario; 2008.
- ⁵⁶ Lasker RD, Weiss ES, Miller R. Promoting collaborations that improve health. *Education for Health*, 2001;14(2):166.
- ⁵⁷ Center for Global Health Communication and Marketing. Community mobilization [Online]. 2009. Available from: http://www.globalhealthcommunication.org/strategies/community_mobilization
- ⁵⁸ Howard-Grabman L, Snetro G. How to mobilize communities for health and social change. Baltimore (MD): Health Communication Partnership/USAID, 2003.
- ⁵⁹ Howard-Grabman L, Storti C editor. Demystifying community mobilization: an effective strategy to improve maternal and newborn health [Online]. Washington DC: USAID/ACCESS; 2007. Available from: http://www.savethechildren.org/publications/programs/health/ACCESS_Demystifying-Community-Mobilization.pdf
- ⁶⁰ Public Health Agency of Canada. Health promotion strategies: promising community empowerment approaches [Online]. 2008. Available from: http://www.phac-aspc.gc.ca/seniors-aines/pubs/best_practices/bp_evidence_for_bp_7e.htm
- ⁶¹ UNAIDS. 2008 report on the global AIDS epidemic, Chapter 3: Addressing societal causes of HIV Risk and vulnerability [Online]. 2008. Available from: http://data.unaids.org/pub/GlobalReport/2008/jc1510_2008_global_report_pp63_94_en.pdf
- ⁶² Center for Disease Control. Capacity building assistance [Online]. 2009. Available from: <http://www.cdc.gov/hiv/topics/cba/index.htm>
- ⁶³ Kristoffel KK. Public health advocacy: process and product. *American Journal of Public Health* 2000; 90(5):722.
- ⁶⁴ McCubbin M, Labonte R, Dallaire B. Advocacy for healthy public policy as a health promotion policy [Online]. 2001. Available from: <http://www.utoronto.ca/chp/download/2ndSymposium/McCubbin,%20Labonte,%20Dallaire.doc>
- ⁶⁵ Hutchinson K. Facilitating outcome evaluations among HIV/AIDS service providers in BC (for B.C. Provincial Health Services Authority) [Online]. 2008. Available from: <http://www.phsa.ca/NR/rdonlyres/51AD09FE-AC78-4440-8330-8337773A900F/28056/PHSAEvaluationReportrevised.pdf>



APPENDICES

FOR OUTREACH PLANNING GUIDE



APPENDIX A: GLOSSARY

BENCHMARK	A measurement or point of reference at the beginning of an activity, such as a survey, or the evaluation or research project, that is used for comparison with subsequent measurements of the same variable.
CSW	Commercial Sex Worker
FORMAL PARTNERSHIPS	Accommodation providers, day centres, drug and alcohol services, health and social services, particularly primary care, mental health services, local ambulance services and the police.
GATEKEEPERS	“Gatekeepers” are influential individuals who can either facilitate or impede access to a community. Gatekeeping may serve several purposes: It may protect vulnerable persons from potentially negative interactions with researchers, allow gatekeepers to speak on behalf of community residents, delineate professional “turfs,” or delineate the types of interactions that will occur between researchers and community members.
HARM REDUCTION	Harm reduction is a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use to abstinence. Harm reduction strategies meet drug users “where they’re at,” addressing conditions of use along with the use itself
HIV	Human immunodeficiency virus
HIV RISK	The probability or likelihood that a person may become infected with HIV. Certain behaviours create, increase, and perpetuate risk. Examples include unprotected sex with a partner whose HIV status is unknown, multiple sexual partnerships involving unprotected sex, and injecting drug use with contaminated needles and syringes.
HIV VULNERABILITY	Results from a range of factors outside the control of the individual that reduce the ability of individuals and communities to avoid HIV risk. These factors may include: (1) lack of knowledge and skills required to protect oneself and others; (2) factors pertaining to the quality and coverage of services (e.g., inaccessibility of service due to distance, cost or other factors); and (3) societal factors such as human rights violations, or social and cultural norms. These norms can include practices, beliefs and laws that stigmatize and disempower certain populations, limiting their ability to access or use HIV prevention, treatment, care, and support services and commodities. These factors, alone or in combination, may create or exacerbate individual and collective vulnerability to HIV.
IDU	Injection Drug User



INFORMAL PARTNERSHIPS	Other public sector workers, local businesses, members of the general public and former rough sleepers.
MOBILIZATION	A capacity building process through which community members, groups, or organizations plan, carry out and evaluate activities on a participatory and sustained basis to improve their health and other conditions, either on their own initiative or stimulated by others.
MSM	Men who have sex with men
NATURAL SETTING	Where people are at- the community, space, or context in which the client feels comfortable and in their own environment.
STBBI	Sexually transmitted blood borne infection
LOW THRESHOLD SERVICES	An important point of entry into the public health system. Low threshold agencies provide public health services, such as counselling, needle programs, shelters, medical care, and education
WET SHELTERS	Alcohol is offered to the clients under supervised conditions.
WRAP AROUND SERVICES	Wrap-around services refers to an individually designed set of services provided to adults with complex health and social issues, including addictions and/or mental illness, that includes treatment services and personal support services or any other supports necessary to increase stability and community functioning.
COMPASSION FATIGUE	Compassion fatigue (also called compassion stress, vicarious traumatization, and secondary PTSD) involves empathically connecting with people going through the emotions of trauma, resulting in experiencing those emotions yourself.
EAP	Employee Assistance Program
PEP	Post-exposure prophylaxis
SAFE ZONES	A place you can feel free to talk without fear of criticism or hatred. It is a place where you can feel not only supported, but affirmed. It is a place where you are not only accepted, but valued.
UNAIDS	Joint United Nations Programme on HIV/AIDS. An innovative joint venture of the United Nations family, bringing together the efforts and resources of ten UN system organizations in the AIDS response to help the world prevent new HIV infections, care for people living with HIV, and mitigate the impact of the epidemic.



APPENDIX B: DEFINING RISK AND VULNERABILITY

Why is it important to define risk and vulnerability in the context of outreach programming for HIV/STBBI?

Effective outreach programs recognize the difference between risk and vulnerability, distinguishing between the risks that lead directly to HIV/STBBI infection and the underlying vulnerabilities. The identification and measurement of risk behaviours associated with HIV is a relatively recent phenomenon, and the combined measurement of risk behaviours and HIV/STBBI rates is referred to as “second generation surveillance”.

The Joint United Nations Program on HIV/AIDS¹ defines HIV Risk and Vulnerability as follows:

Risk is defined as the probability or likelihood that a person may become infected with HIV. Certain behaviours create, increase, and perpetuate risk. Examples include unprotected sex with a partner whose HIV status is unknown, multiple sexual partnerships involving unprotected sex, and injecting drug use with contaminated needles and syringes.

Vulnerability results from a range of factors outside the control of the individual that reduce the ability of individuals and communities to avoid HIV risk. These factors may include: (1) lack of knowledge and skills required to protect oneself and others; (2) factors pertaining to the quality and coverage of services (e.g., inaccessibility of service due to distance, cost or other factors); and (3) societal factors such as human rights violations, or social and cultural norms. These norms can include practices, beliefs and laws that stigmatize and disempower certain populations, limiting their ability to access or use HIV prevention, treatment, care, and support services and commodities. These factors, alone or in combination, may create or exacerbate individual and collective vulnerability to HIV.

In Canada, deficits in these determinants have created vulnerabilities, which have had an impact upon the health and wellness of commercial sex workers (CSWs), injecting drug users (IDUs), and men who have sex with men (MSM). More specifically, poverty, a lack of education and jobs, inequality and prejudice, violence, and the criminalisation of addictions and sex work have decreased the opportunities to develop the knowledge and skills needed to prevent HIV/STBBIs, access and use health and social services, and overcome societal factors such as stigma and discrimination that disempower people and limit their potential. Vulnerability goes a long way towards explaining why some groups are disproportionately affected by HIV/STBBIs, as well as a number of other infectious and chronic diseases.

Given this, there is a need to ensure that outreach programming articulates a clear causal link between the social determinants of health, vulnerability and a heightened risk of HIV/STBBI, and develops appropriate programming interventions for both risk and vulnerability reduction.

1. UNAIDS. 2008 report on the global AIDS epidemic, Chapter 3: Addressing societal causes of HIV Risk and vulnerability [Online]. 2008. Available from: http://data.unaids.org/pub/GlobalReport/2008/jc1510_2008_global_report_pp63_94_en.pdf



APPENDIX C: HARM REDUCTION PRINCIPLES

Harm Reduction Principles and their Applicability to Outreach Programming

The principles of Harm Reduction are also relevant to the conduct of outreach – non-judgmental; realistic; respect for individuals, their agency, and the complexity of their situations; and, an understanding of the wider societal context which creates vulnerable groups and individuals.

- Accepts, for better and for worse that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviours from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
- Establishes quality of individual and community life and well-being--not necessarily cessation of all drug use--as the criteria for successful interventions and policies.
- Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
- Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.
- Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.
- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.
- Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.

1. Harm Reduction Coalition. Principles of harm reduction [Online]
Available from: <http://www.harmreduction.org/article.php?list=type&type=62>



APPENDIX D: THEORY OF BEHAVIOUR CHANGE

Theories of Behaviour Change:

- View change as a process rather than an event
- The change process is characterized by a series of stages of change
- In attempting to change a behaviour a person typically cycles through these stages of change

Health Belief Model¹ focuses on an Individuals' perceptions of

- the threat posed by a health problem,
- the benefits of avoiding the threat, and
- factors influencing the decision to act

<i>Concept</i>	<i>Definition</i>	<i>Potential Change Strategies</i>
Perceived susceptibility	Beliefs about the chances of getting a condition	<ul style="list-style-type: none"> • Define what populations(s) are at risk and their levels of risk • Tailor risk information based on an individual's characteristics or behaviors • Help the individual develop an accurate perception of his or her own risk
Perceived severity	Beliefs about the seriousness of a condition and its consequences	<ul style="list-style-type: none"> • Specify the consequences of a condition and recommended action
Perceived benefits	Beliefs about the effectiveness of taking action to reduce risk or seriousness	<ul style="list-style-type: none"> • Explain how, where, and when to take action and what the potential positive results will be
Perceived barriers	Beliefs about the material and psychological costs of taking action	<ul style="list-style-type: none"> • Offer reassurance, incentives, and assistance; correct misinformation
Cues to action	Factors that activate "readiness to change"	<ul style="list-style-type: none"> • Provide "how to" information, promote awareness, and employ reminder systems
Self-efficacy	Confidence in one's ability to take action	<ul style="list-style-type: none"> • Provide training and guidance in performing action • Use progressive goal setting • Give verbal reinforcement • Demonstrate desired behaviors



Stages of Changes Theory²

- Individuals' motivation and readiness to change a problem behaviour

Stage of Change	Techniques/Interventions
<p>Pre-contemplation</p> <ul style="list-style-type: none"> • Not currently considering change: "Ignorance is bliss" 	<ul style="list-style-type: none"> • Validate lack of readiness • Clarify: decision is theirs • Encourage re-evaluation of current behaviour • Encourage self-exploration, not action • Explain and personalize the risk
<p>Contemplation</p> <ol style="list-style-type: none"> 1. Ambivalent about change: "Sitting on the fence" 2. Not considering change within the next month 	<ul style="list-style-type: none"> • Validate lack of readiness • Clarify: decision is theirs • Encourage evaluation of pros and cons of behaviour change • Identify and promote new, positive outcome expectations
<p>Preparation</p> <ul style="list-style-type: none"> • Some experience with change and are trying to change: "Testing the waters" • Planning to act within 1 month 	<ul style="list-style-type: none"> • Identify and assist in problem solving re: obstacles • Help patient identify social support • Verify that patient has underlying skills for behaviour change • Encourage small initial steps
<p>Action</p> <ul style="list-style-type: none"> • Practicing new behaviour for • 3-6 months 	<ul style="list-style-type: none"> • Focus on restructuring cues and social support • Bolster self-efficacy for dealing with obstacles • Combat feelings of loss and reiterate long-term benefits
<p>Maintenance</p> <ul style="list-style-type: none"> • Continued commitment to sustaining new behaviour • Post-6 months to 5 years 	<ul style="list-style-type: none"> • Plan for follow-up support • Reinforce internal rewards • Discuss coping with relapse
<p>Relapse</p> <ul style="list-style-type: none"> • Resumption of old behaviors: "Fall from grace" 	<ul style="list-style-type: none"> • Evaluate trigger for relapse • Reassess motivation and barriers • Plan stronger coping strategies



Theory of Planned Behaviour¹

- Individuals' attitudes toward a behaviour,
- perceptions of norms, and
- beliefs about the ease or difficulty of changing

The Theory of Planned Behaviour explores the relationship between behaviour and beliefs, attitudes, and intentions. This theory assumes behavioural intention is the most important determinant of behaviour and behavioural intention is influenced by a person's attitude toward performing a behaviour, and by beliefs about whether individuals who are important to the person approve or disapprove of the behaviour (subjective norm). The theory assumes all other factors (e.g., culture, the environment) operate through the models' constructs, and do not independently explain the likelihood that a person will behave a certain way.

<i>Concept</i>	<i>Definition</i>	<i>Measurement Approach</i>
Behavioral intention	Perceived likelihood of performing behavior	Are you likely or unlikely to (perform the behavior)?
Attitude	Personal evaluation of the behavior	Do you see (the behavior) as good, neutral, or bad?
Subjective norm	Beliefs about whether key people approve or disapprove of the behavior; motivation to behave in a way that gains their approval	Do you agree or disagree that most people approve of/disapprove of (the behavior)?
Perceived behavioral control	Belief that one has, and can exercise, control over performing the behavior	Do you believe (performing the behavior) is up to you, or not up to you?

¹ U.S. Department of Health and Human Services, National Institute of Health. Theory at a glance, a guide for health promotion practice, 2nd Ed. 2005.

² Prochaska JO, DiClemente CC, Norcross JC. In search of how people change. Am Psychol 1992;47:1102-4



APPENDIX E: CANADIAN DATA SOURCES SPECIFIC TO VULNERABLE POPULATIONS

Several federal data sources on national and specific vulnerable populations are presented here, as well as two sources from Ontario. It is recommended that program implementers also become familiar with provincial level morbidity surveys, administrative data (e.g., hospitalisation records), notifiable disease reporting systems, and relevant disease registries, as well as the demographic and epidemiological data collected by local health and social service units.

- Census Tract (CT) Profiles, 2006 Census, are small geographic areas for which census data is available, usually urban areas. <http://www12.statcan.ca/census-recensement/2006/dp-pd/prof/92-597/index.cfm?Lang=E>
- Statistics Canada Community Profiles offering basic information, including health information. <http://ceps.statcan.ca/english/profil/PlaceSearchForm1.cfm>
- Statistics Canada's Annual Demographic Statistics most recent version is 2005. <http://www.statcan.gc.ca/pub/91-213-x/91-213-x2005000-eng.pdf>
- Health Indicators is produced jointly by Statistics Canada and the Canadian Institute for Health Information (CIHI). It is a compilation of indicators measuring (1) health status, (2) non-medical determinants of health, (3) health-system performance and (4) community and health-system characteristics. These indicators are produced at the health region level, as well as at provincial territorial and Canada levels. <http://www.statcan.gc.ca/pub/82-221-x/82-221-x2006001-eng.htm>
- M-Track Survey is a 2nd generation surveillance system, regularly repeated at different sites across Canada -- uncovering trends in HIV, viral hepatitis (hepatitis C), sexually transmitted infections and related risk behaviours among gay, bisexual men, two-spirit men, and other men who have sex with men. <http://www.phac-aspc.gc.ca/aids-sida/about/mtrack-eng.php>
- I-Track Survey is a 2nd generation surveillance system with regularly repeated surveys conducted at various sites across Canada -- uncovering trends of HIV- and Hepatitis C - associated injecting and sexual risk behaviours among people who inject drugs. The surveys are usually repeated every two years. <http://www.phac-aspc.gc.ca/aids-sida/about/itrack-eng.php>
- Enhanced Surveillance of Canadian Street Youth (E-SYS) is a multi-site 2nd generation surveillance system that monitors STI and blood-borne pathogen rates, behaviours and risk determinants in street youth. Surveys are repeated every two years. <http://www.phac-aspc.gc.ca/sti-its-surv-epi/youth-jeunes-eng.php>
- Public Health Agency of Canada (PHAC) offers a range of publications on infectious diseases. <http://www.phac-aspc.gc.ca/id-mi/index-eng.php>
- Association of Public Health Epidemiologists in Ontario publishes a list of core indicators which should be captured at the health unit level. www.apheo.ca
- The Rapid Risk Factor Surveillance System (RRFSS) is a recurring telephone survey of a set of risk factors reported by Ontario health units. It is good for alcohol/tobacco use and chronic disease. Full access requires subscription. <http://www.rrfss.on.ca/index.php?pid=21>



APPENDIX F: GEOGRAPHIC MAPPING FEASIBILITY STUDY

WINNIPEG HIGH RISK ACTIVITY (HRA) GEOGRAPHIC MAPPING FEASIBILITY STUDY

LESSONS LEARNED AND RECOMMENDATIONS

1. A critical determinant of the success of a mapping exercise is the recruitment, selection and training of a Research Coordinator and Field Workers with the appropriate backgrounds, experience and personal attributes to enable an effective street-based outreach approach to data collection.
2. Flexibility in adapting data collection methods to specific neighbourhood contexts is critical.
3. While the mapping methods can be applied relatively quickly, a sufficient amount of time is needed to do the necessary community consultations in the study setup phase, and to conduct the field work in each neighbourhood necessary to learn the community context, identify key informants and account for variations in level of HRA from week to week. It is recommended that a minimum of two months be allocated for the start up phase (community consultation and development) of future mapping exercises, with a minimum of two weeks of field data collection for each neighbourhood.
4. High risk activities need to be precisely defined in future mapping protocols. Field definitions in the pilot study were modified to focus on: injection drug use where sharing of equipment was likely to occur, anonymous/cruising MSM, and street-based transactional/commercial sex work.
5. Contemporary electronic social networking and communication tools (e.g., Internet, text-messaging) should be considered and used where appropriate in mapping data collection.
6. Boundaries employed for area mapping should be the natural boundaries of neighbourhoods as defined by community members. Use of sometimes-arbitrary health or political administrative boundaries imposes artificial constraints and may introduce bias into the data collected.
7. High risk activities vary over place and time (e.g., by season in Canadian cities with harsh winters.) Mapping should be conducted at different times of the year, and repeated regularly.
8. The study supported existing literature which indicates that mapping of HRA can form one component of comprehensive needs assessment for community-based HIV prevention; to be useful, mapping must be complemented by qualitative (ethnographic) and survey data.

¹ Ormand M, Elliot L. WIN-MAP: A feasibility study of geographic mapping of places in Winnipeg with high levels of HIV-related risk activity—final report. Winnipeg, Manitoba: University of Manitoba; 2008. p. 32. Unpublished.



APPENDIX G: DOCUMENTING A SITUATIONAL ASSESSMENT

The purpose of a situational assessment is to ground program/policy planning decisions in a variety of evidence. Through reviewing the evidence gathered during the situational assessment, priority populations and suitable practices can be identified. The results of the situational assessment are used to generate recommendations for the program design and guide service delivery.

Begin by creating a focused, answerable question (i.e., clarify what you need to find out). Then, examine and document the following information in a way that helps to answer the question.

1. Surveillance and population health assessment data

Types of population health data/information to consider (as applicable):

- Socio-economic & demographic
- Mortality & morbidity
- Reproductive outcomes
- Growth & development outcomes
- Risk factors & health behaviours; preventive health practices
- Physical environment
- Attitudes, awareness & knowledge regarding health practices
- Health status/outcomes

Sources of data to consider:

- Information systems
- Administrative databases
- Surveys
- Other primary data collection
- Data/reports from other sources

2. Literature and evaluation findings

- Current literature
- Evaluation results



3. Stakeholder perspectives

Systematically gather and document information from stakeholders in the decision, which may include:

- Clients/participants
- Community/public
- Staff
- Professional and community partners
- Others (as applicable), e.g., other health units

4. Context

Consider factors that may affect the initiative:

- Political, economic, environmental, social, technological, and other factors
- Strengths (capacities, resources); weaknesses (limitations); opportunities; threats (barriers); potential risks & benefits

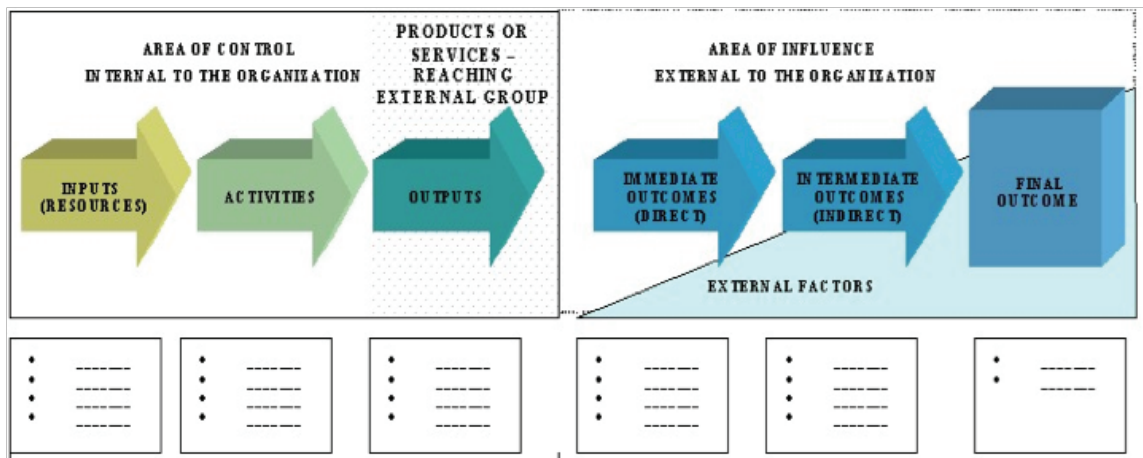


APPENDIX H: LOGIC MODELS

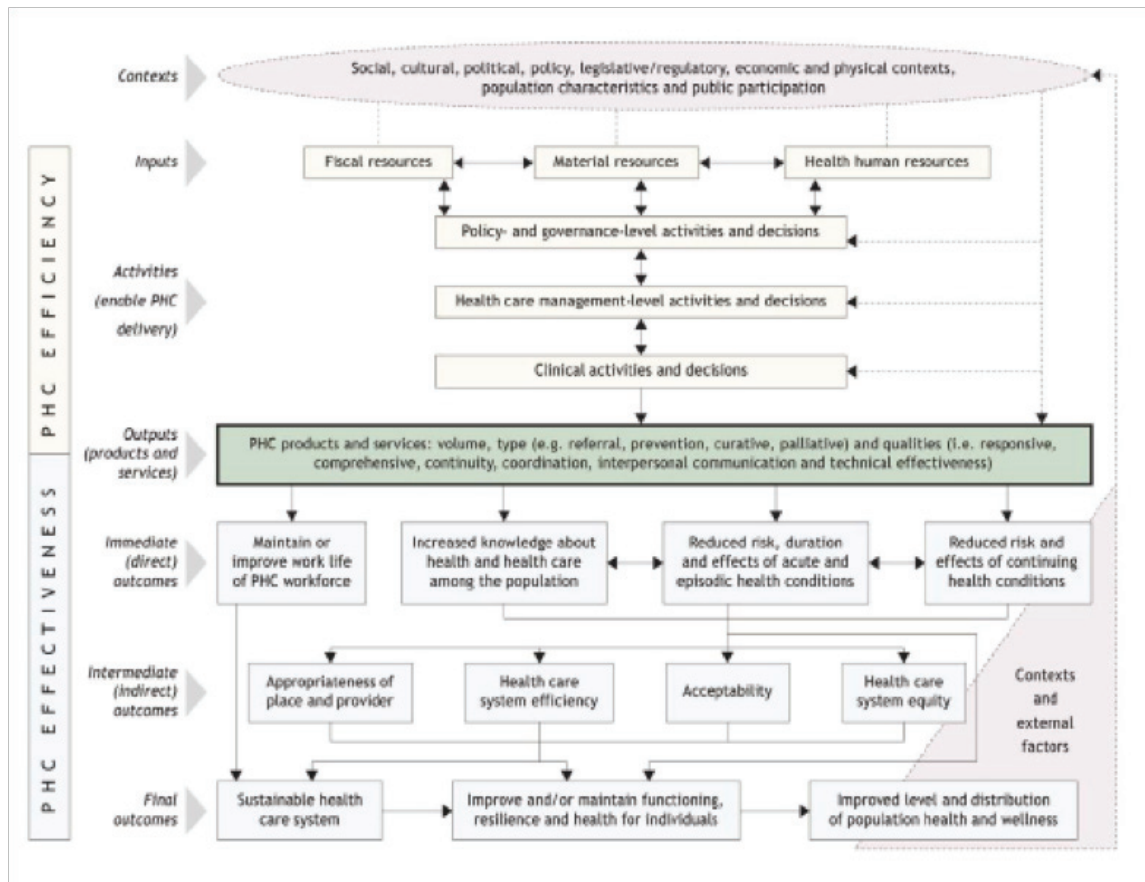
A logic model, also called a results chains, is “A depiction of the causal or logical relationships between inputs, activities, outputs and the outcomes of a given policy, program or initiative.”¹ It tells a story that says “If resources are invested to deliver activities to reach a population, it is likely that the following results will be achieved in the immediate-, medium-, and long-term...” A logic model is a *description of how the program should work*. Logic models are not without their weaknesses. These include an inability to describe how the results will be achieved, the structure of accountability, or the main assumption and risks associated with the expected results.²

Two logic models are presented below. The first is a simple generic version from the federal government’s Treasury Board Secretariat of Canada (TBS), which shows the general six steps in a horizontal “results-chain” format. The second was developed by CHSPR in a vertical “flow chart” format, and has been developed specifically for Primary Health Care programming.

Treasury Board Secretariat of Canada Generic “Results Chain” Logic Model¹



UBC CHSPR Primary Health Care Programming “Flow Chart” Logic Model³



Five additional points on the Logic Model:

1. Reach is not usually included in a logic model as it is not a “step” in the chain of results. However, as discussed, when seeking to prevent and treat infectious diseases, it is essential that programming reach a substantial proportion of a vulnerable population in order to have an impact. It is known that harm reduction programs need to cover as many IDUs as possible in a geographic area or “...there is a danger of becoming a boutique program that has little or no impact on an HIV epidemic”.⁴
2. The concepts of “control” and “influence” are important to understanding the loss of programmatic control as one goes from activity to results. For example, while a program might control condom distribution, it can only influence a person’s decision to use them. Adequate resources, reach or coverage of a vulnerable population and the quality of outreach can increase the program’s ability to increase its influence.



3. Linked to control and influence, is the issue of accountability for expected results, which is “The obligation to demonstrate and take responsibility both for the means used and the results achieved in light of agreed expectations.”¹ But if results can only be influenced, how can a program be accountable for them? This is an important question and best understood in terms of primary or shared accountability. Generally, the closer a logic model moves to its final results, the more shared accountability there is. For example while a Bath House HIV prevention program would have primary accountability for condom use among bath house patrons, it would share accountability for HIV/STBBI rates among MSM with a range of health and social service providers.
4. It is important to know the assumptions and risks within a logic model. Every program is planned based upon a combination of theory, evidence and assumption. Assumptions could include a belief in consistent funding or that behaviours can be changed. Risks could include political opposition or changes in HIV/STBBI transmission dynamics. As one moves along the logic model from activity to result, from control to influence, the assumptions and risks tend to grow.
5. A final point is on the inclusion of programming approaches or strategies in a logic model. Most logic models do not include them. Some do, usually as a step immediately before or after the outputs or as a part of the outputs. The sample logic model developed by NCCMT and THCU in the Online Health Program Planner includes a line for strategies.⁵

¹ Guide to the Development of Results-Based Management and Accountability Frameworks; Annex A - Results-Based Management Lexicon. Treasury Board Secretariat of Canada. [Online] 2009. Available from: http://www.tbs-sct.gc.ca/rma/lex-lex_e.asp.

² Rabinovitch A. Realizing more benefits from logic models: what logic models can learn from benefits realization. Presentation to Canadian evaluation society—National Capital Region Area [Online]. 2007. Available from: http://ncc.evaluationcanada.ca/downloads/presentations/bs_0607/LM_rabinovitch_0607.pdf

³ Watson DE, et al. A Results-Based Logic Model for Primary Health Care. Laying an Evidence-Based Foundation to Guide Performance Measurement, Monitoring, and Evaluation. [Online] 2004. Available from: <http://www.chspr.ubc.ca/files/publications/2004/chspr04-19.pdf>.

⁴ AIDS Projects Management Group. Guide to Starting and Managing Needle and Syringe Programmes (WHO, UNAIDS and UNODC, 2007): 6.

⁵ Available from http://www.thcu.ca/ohpp/output/logic_model_sample_en.pdf



APPENDIX I: CONCEPTUAL AND PROGRAMMING CHALLENGES FOR OUTREACH

The literature and various stakeholders identified a number of challenges to conceptualising outreach and developing and delivering outreach as a programming approach.

- The inability to determine a population's size and a program's reach make it difficult to effectively provide services and measure their impact. "Hidden" vulnerable populations are difficult to find and reach—they are mobile and suspicious. Their lives can be subject to arbitrary and unpredictable forces (e.g. police, weather, illicit drug markets, and policy changes). These all contribute to the difficulty in determining population size.
- Developing a program which deals with the natural variations of HIV/STBBI prevalence within a population and the changing characteristics of epidemics over time is difficult. This includes being able to match outreach strategies to the stage of a particular epidemic or the prevalence of a particular disease or infection or the patterns and methods of use of a particular intoxicant.
- Difficulties finding and using high-quality program evidence and population health, behavioural, and demographic data, can lead to a reliance on observation, anecdote, and community relationships and a tendency to do what has worked before and is familiar.
- Changing funding levels and priorities create a lack of predictability and continuity. Service providers are often put in the position of applying for funding in one area to meet a need in another. For example, the emergence of hepatitis C as a funding priority has occurred in situations where HIV and other STBBIs remain significant health threats.
- Weak or unclear evaluation or performance measurement frameworks make it difficult to assess program relevance, effectiveness/efficiency, and impact.
- Partnership development driven by "lead agencies" instead of collaborative processes and inconsistent approaches to engaging with client communities can reduce programming effectiveness. Working with partners with different "scopes of practice" and different philosophical approaches to sex work or addictions can increase complexity.
- Working in legal and ethical "grey" areas with vulnerable populations engaged in, or affected by illegal or socially unacceptable activities creates challenges. Programming for vulnerable populations has always been subject to scrutiny and occasional opposition from elected officials, police services, community groups, and the media.
- Competition between agencies representing particular agendas or constituencies, fragmented funding, and the horizontal organization of programming into silos of health conditions (e.g. HIV/AIDS, addictions), sub-populations (e.g. MSM, CSW), or specific issues (e.g. homelessness, gang violence), can lead to confusion, redundancy, inefficiency, and clients needs not served. It can also create the unproductive tendency to claim ownership of a particular client constituency.
- Frontline staff are the foundation of outreach programming but at the bottom of the medical and social service hierarchies. They are often not well paid, and do not receive the attention, respect, and validation they deserve; contributing to high burn-out and turn-over rates.



Program planners are often challenged to find the best balance between different approaches rather than choosing one over another.

1. Provide services to individuals in their natural settings and/or mobilize them to access conventional (fixed-site) services and/or build group solidarity and a sense of community.

All outreach programs should seek the best balance of these components. This is not a simple process, but one which must consider logistical, legal, and clinical issues. Other considerations could include availability of resources, organizational capacity and infrastructure, past interventions, staffing, donor agendas, inter-agency relations, and the politics of working with vulnerable groups. For example something as simple as laws on public urination can limit the ability of outreach to collect urine for laboratory testing.

Building solidarity and a sense of community is the least developed aspect of outreach programming. The argument for the use of a community development approach in vulnerable population health programming has two parts. The first is that a population's marginalisation contributes to its poor health status, while its empowerment can lead to better outcomes. The second is that risk behaviours can be reduced by changing community norms (e.g., not sharing syringes) and engaging them to support the protection of their own health.

2. Reduce the immediate harm of risk behaviours and situations while promoting long-term wellness

Outreach interventions, particularly where addictions are involved, should balance reducing imminent harm with promoting longer-term wellness—a key principle in harm reduction. The decision of where to place outreach on this continuum can lead to very different interventions. For example, can drug use be both a personal choice to be respected (while limiting its harm) and a destructive behaviour to be discouraged? Can harm reduction and low threshold services (e.g., wet shelters) be balanced with those requiring abstinence? What is the balance between respecting the rights of the mentally ill and promoting compliance with care regimens?

Personal choices are frequently guided by principles and values. Public agencies need to be aware of this tension while respecting the approaches of their partners. Outreach, like harm reduction, should aim to meet clients “where they’re at” in their lives, addressing both current concerns and the underlying foundations or circumstances.¹ This allows for a range of options, including reducing the risk of imminent harm and promoting long-term wellness through positive behaviour change and reducing the underlying vulnerabilities.



3. Reduce the risks and vulnerabilities facing individuals while acknowledging the group norms of the vulnerable population

Outreach programs need to balance their focus between vulnerable individuals and entire vulnerable communities. There is significant support within the literature, particularly from programs using peer workers to create healthier shared norms. Such programs use existing networks and community leadership (Indigenous leaders) and build group solidarity and a sense of community in pursuit of specific behaviour changes. This works because groups can "...provide the psychological support that many individuals need to practice safe sex..."² and develop other healthier practices, including the skills to deal with the wider challenges (vulnerabilities) that the group faces.

Working with the leaders of vulnerable communities can provide access to those who wish to remain hidden. These leaders can also use their position to advocate for the program's messages and play an active role in delivering them.³

Gatekeepers can also block access to outreach programming for well-intentioned reasons, such as a desire to protect community members from stigmatization, intrusion, and harm, or to protect organization "turf" or a fear of a loss of control or income. Regardless of the reasons, they need to be included in the planning of outreach interventions.

4. Focus programming on a specific population and/or a particular disease

HIV/STBBI outreach programs for vulnerable populations usually have several foci that combine preventing and treating specific infectious diseases among specific vulnerable populations. This is a fairly sensitive area, with a number of programming and political pitfalls. For example, an HIV prevention program that did not differentiate between CSWs, IDUs, and MSM would not grasp the unique vulnerabilities underlying risk behaviours in each group. Likewise, a population-specific program that overemphasised vulnerability and paid less attention to risk behaviours and the relevant transmission dynamics could fail.

In reality, most outreach programs try to find a suitable balance between the two approaches. A sex workers' rights organization may place HIV/STBBI prevention in the wider context of sex worker vulnerability and conceptualise it as a workplace safety issue, whereas a public health department sees risk behaviours and situations and responds from the perspective of interrupting transmission. Both approaches are valuable and necessary for successful programming.



5. A stand-alone intervention or an integrated part of a larger cohesive program

Outreach is rarely a stand-alone program but either part of a larger public health initiative or a network of partners. As outreach is most often employed as a component of larger health and social service programs, there is a need to decide how best to integrate it into these larger programs and support their overarching objectives.⁴ This includes clearly explaining the role of outreach in the larger program, through such programmatic means as organizational support, job descriptions, resources, and being part of the larger program team.⁵ This can be more difficult with smaller, stand-alone, community-based outreach initiatives that exist in smaller communities and rely heavily on voluntary efforts.

Whether HIV/STBBI outreach for vulnerable populations is a small stand-alone intervention or part of a larger program, there is usually a need to develop inter-agency partnerships. By themselves, large public health agencies may not have the connections needed to access hidden populations, and small community-based organizations may not have the technical expertise to prevent and treat HIV/STBBIs. Partnerships and collaborative arrangements can exploit the strengths of various agencies working in this field in order to provide the “wrap-around” services that vulnerable clients, with complex and multiple needs, require.

The quality of these partnerships and the role of community-based organizations, particularly those rooted in vulnerable communities, in directing and participating in programming can play a role in programming success. Other benefits of collaboration are a strengthened advocacy voice and increased control over both health and social service challenges and the working environment.⁶

6. Accessing the client in “open” and/or “closed” settings

Working with vulnerable populations may mean working with individuals engaged in socially unacceptable, illegal, and (by necessity) hidden activities. Such activities are often organised by informal networks (e.g., sex work) and can occur in “open” (public) and “closed” (private) spaces, both of which have programming, legal, and safety concerns.⁴ To access private spaces, outreach requires an “invitation” and this means building relationships with vulnerable communities.

Outreach can also occur in controlled closed settings managed by agencies. The concept of “Building-Based Outreach” encourages client’s to visit drop-in centres and other indoor service facilities to arrange for referrals to services and provides a safe, clean and welcoming environment.⁷



7. Outreach delivered by professional outreach staff or community peer workers

Reviews of peer work has shown it to be an effective approach as peer workers can access hidden and distrustful communities and build their trust in the program. They can be program “ambassadors”, a source of information, and a sounding board. Outreach teams combining the community knowledge and access of peer workers with the professional skills of someone like a public health nurse can offer a broad range of services. Network-focused HIV interventions that use peers to build group identity and promote pro-social roles among IDUs resulted in safer injection and sex practices, when compared to a control group.^{8,9}

However, there are challenges with the use of peers. They can be difficult to supervise, particularly if drugs are involved. There are concerns about turnover and liability, as well as negative perceptions of public agencies using (and paying) people engaged in illegal activities. Programs need to decide what peers will do and how they will fit into a larger organization. One thing that is known is that peers, like volunteers, are not “free”. They require a large investment in selecting, training, supervising, and supporting. They should not be seen as a low cost alternative to paid professional staff.

¹ Harm Reduction Coalition. Principles of harm reduction [Online] Available from: <http://www.harmreduction.org/article.php?list=type&type=62>

² Macchiwalla T, Bhattacharjee P, Anthony J. Community-led outreach: An outreach strategy for focused prevention of HIV in urban sex work interventions. Rajajinagar, Bangalore: Karnataka Health Promotion Trust; 2006.

³ World Health Organization. Evidence for action: effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users [Online]. Geneva: World Health Organization; 2004. Available from: <http://www.who.int/hiv/pub/idu/idu/en/>

⁴ Ford C et al. Key components of a theory-guided HIV prevention model: pre-outreach preparation, community assessment, and a network of key informants. *AIDS Education and Prevention* 2007;19(2):176.

⁵ Tembreull CL, Schaffer MA. The intervention of outreach: best practices. *Public Health Nursing* 2005;22(4):350.

⁶ Lasker RD, Committee on Medicine and Public Health. *Medicine and public health: the power of collaboration*. New York (NY): The New York Academy of Medicine; 1998.

⁷ Homeless Link. *Streets ahead: good practice in tackling rough sleeping through street outreach services* [Online]. London, England: Homeless Link; 2008. Available from: www.handbooks.homeless.org.uk

⁸ Latkin CA, Sherman S, Knowlton A. HIV prevention among drug users: outcome of a network-oriented peer outreach intervention. *Health Psychology*, 2003;22(4):332-339.

⁹ Weeks, M, Li, J., Dickson-Gomez, Convey, M., Martinez, M., Radda, K. & Clair, S. Outcomes of Peer HIV prevention program with injection drug and crack users: The risk avoidance partnership. *Substance Use & Misuse* 2009; 44: 253.



APPENDIX J: “DUTY TO WARN”

CANADIAN FRONTLINE WORKERS AND DISCLOSURE

Hospitals, psychiatrists, social workers and police have all been found by courts to have a duty in some circumstances to warn someone they can identify as being at risk. As of this writing, no cases specifically related to HIV have been decided. Under current Canadian law, it is not clear whether other counsellors have a legal obligation to disclose confidential information about a client in order to prevent harm to another person. However, they do have the discretion (i.e., permission) to do so where

- there is a clear risk of harm to an identifiable person or group of persons
- there is a significant risk of serious bodily harm or death
- the danger is imminent

If all three conditions are met and the counsellor decides to breach confidentiality in order to protect another person, the disclosure of confidential information should be as limited as possible...

The Canadian Medical Association advises physicians that disclosure to a spouse or sexual partner may be warranted if an HIV-positive patient’s partner is at risk of HIV infection, the patient refuses to inform the sexual partner, the patient has refused an offer of assistance to inform the partner on the patient’s behalf, and the physician first informs the patient of the intention to contact the partner. The Canadian Association of Social Workers says that the general expectation of confidentiality does not apply when disclosure “is necessary to prevent serious, foreseeable and imminent harm” to others.

¹ Canadian HIV/AIDS Legal Network. Criminal law and HIV [Online] 2008.
Available from: <http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1318>



APPENDIX K: ORGANIZATIONAL FACTORS THAT SUPPORT POSITIVE WORK ENVIRONMENTS

In The Child Welfare Challenge, eight organizational factors which contribute to a good working environment for frontline workers are identified. Seven of those factors are applicable to outreach workers:

- Articulation of a clear organizational mission and program philosophy.
- An effective organizational plan.
- Sound personnel recruitment, selection, and training.
- Professionalization of child welfare work.
- Clear organizational performance measurement and staff appraisal criteria.
- Quality supervision of frontline staff.
- Collection and use of programming performance data, including client feedback.¹

A study of Canadian child welfare workers listed several indicators of good practice relevant to the management of frontline staff. These are also applicable to outreach.

- Personal and professional satisfaction.
- Adherence to a Code of Conduct and ethical principles.
- Focus on serving clients.
- Broader professional role understood and supported; obstacles understood, competing goals and mandates balanced, and all involved work as a team.
- Personal and professional development opportunities.
- Employee wellness and high staff morale.
- Accountability and an ability to prove whether the work has had a positive impact.²

¹ Pecora, P, Whittaker J, Maluccio A. The child welfare challenge: Policy, practice and research. New York: De Gruyter; 1992.

² Herbert M. Child welfare project: Creating conditions for good practice [Online]. 2003.
Available from: URL:<http://www.cecw-cepb.ca/publications/1020>



APPENDIX L: OUTREACH WORKER QUALIFICATIONS

The Street Outreach Training Manual, a document developed for outreach to street youth, identifies suggested outreach worker qualifications:¹

- Staff can be homogenous or can have different qualifications, education levels, personality types, and experiences.
- Team members can include: professionals, volunteers, and peer workers.
- Team members will need to be able to:
 - build trust,
 - handle tense and complex situations with flexibility, creativity and confidence,
 - be self-starters,
 - maintain boundaries, and
 - work as team members

There is some evidence that no personality type is more effective than any other at doing outreach and that in fact, programs can benefit from a range of personalities, employing them creatively to deal with challenging clients.²

It is noted that many of the characteristics that make someone good at outreach are also things that make them less inclined to complete their paperwork or fit into the corporate cultures of larger agencies.¹

¹ Peterson TA, Bucy J. Chapter 4- The outreach team. In The street outreach training manual. [Online]. Washington (DC): U.S. Department of Health and Human Services; 1993. Available from: http://www.eric.ed.gov/ERICDocs/data/ericdocs2sql/content_storage_01/0000019b/80/13/3d/0a.pdf

² Ford C et al. Key components of a theory-guided HIV prevention outreach model: pre-outreach preparation, community assessment, and a network of key informants. *AIDS Education and Prevention*, 2007;19(2):175.



APPENDIX M: NINE CIRCLES OUTREACH WORKER SUPPORT

Nine Circles (Winnipeg) believes that the sustainability of outreach teams depends upon:

- safety guidelines,
- team support,
- evaluation,
- continuing education, and
- Employee Assistance Program (EAP)

They also believe that it is imperative to support team members exposed to the trauma of clients' lives and deaths, if they are not to burn-out, quit, or become low-functioning.

...mental health therapists meet with the Outreach team on a monthly basis for 1 ½ hours. During this time a variety of needs and issues are being addressed. These meetings are a forum for the team to process outstanding issues with clients that have a psychosocial aspect. It is an outlet to express struggles and reinforce healthy communication styles. The focus or topics covered in the meetings are evolving and changing according to the team's requirements. There is a psycho-education component, which involves some teaching and role playing. The team gives mutual support and encouragement to each other as they share common struggles. Some topics covered have been boundaries with clients and agencies; reporting abuse, and developing treatment plans. Future topics considered are motivational interviewing, stages of change and working with the client who is not a "customer." The Outreach Team has a wealth and variety of life experience and background. These meetings allow them to share this with each other and honor themselves.¹

1. Nine Circles Community Health Centre. Outreach team training and resource manual (a work in progress). Winnipeg, Manitoba, Canada: Nine Circles Community Health Centre; 2008. Unpublished.



APPENDIX N: PARTNERSHIP SYNERGY

Operationalisation of Partnership Synergy

The effectiveness of a partnership can be assessed by asking whether partner involvement and contributions allow the partnership to:

- Think about its work in creative, holistic and practical ways
- Develop realistic goals that are widely understood and supported
- Plan and carry out comprehensive interventions that connect multiple programs, services and sectors
- Understand and document the impact of its actions
- Incorporate the perspectives and priorities of community stakeholders, including the target population
- Communicate how its actions will address community problems
- Obtain community support

The determinants of partnership synergy are:

- **Resources**
 - Money, space, equipment, goods
 - Skills and expertise
 - Information
 - Connections to people, organizations, groups
 - Endorsements
 - Convening power
- **Partner characteristics**
 - Heterogeneity
 - Level of involvement
- **Relationships among partners**
 - Trust and respect
 - Conflict
 - Power differentials



- **Partnership characteristics**
 - Leadership and governance
 - Administration and management
 - Efficiency

- **External environment**
 - Community characteristics
 - Public and organizational policies

¹ Lasker RD, Weiss ES, Miller R. Partner synergy: a practical framework for studying and strengthening the collaborative advantage. *The Milbank Quarterly* 2001;79(2):188-189.

