***Photographer: Michelle Lefade**

Peers Outreaching Mitigating Risks

A project evaluation of

HIPS

HEALTHY INITIATIVES FOR PREVENTION AND SAFETY

Peers Outreaching Mitigating Risks

Evaluation Report on the Healthy Initiatives Promoting Safety (HIPS) Project

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We would like to thank all the project staff and women who shared their experiences for this evaluation.

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FOREWORD

Sex workers and women injecting drugs face complex barriers in access to social determinants that impact their health resulting in heightened risks and vulnerabilities to HIV and STI. Despite evidence of growing rate of HIV and STI transmission amongst these populations, as pointed out by the United Nations Office on Drugs and Crime (UNODC) 2014 policy brief, research and evidence based policy and programs addressing the needs of these women have been woefully inadequate.

The Healthy Initiatives Promoting Safety (HIPS) project was started to reduce and prevent HIV infections among street based sex working women and women involved in substance use using a peer based model that provides outreach and addresses their barriers to health care. The HIPS project aims to mitigate and prevent HIV risks by providing HIV prevention information, needle exchange, safer smoking kit distribution, and condom distribution to enhance safer sex and drug use practices. The project facilitates linking women to point of care testing enabling voluntary HIV testing and counseling. In addition the project also aims to connect women to support services according to their need to promote access to health care.

The project was developed based on community empowerment principles that recognizes and values lived experiences of communities directly impacted by the health issues. The peer driven model engaged peers as the key agent of change. This was essential in enabling the effective engagement and building of trust amongst street based sex workers with the project, enabling marginalized women to break out of their isolation and developed new connections to other peers and support services.

Enabling access to information and support

The evaluation study reveals that the peer workers are able to use their experiential knowledge to engage sex workers and provide HIV education and resources to address issues raised by the women. The presence of peers was identified by the women as the key criteria that enabled comfort in accessing safer sex and harm reduction information and supplies, and facilitated access to health and supportive services. Impressively, 90 percent of the participants interviewed indicated that the information and support provided by the peer workers directly influenced their decision to access POC testing.

Facilitating community empowerment

The peer engagement strategy in HIPS also facilitated capacity building and mutual empowerment amongst the peer outreach workers in the project. The peers all cited various

psychosocial benefits such as an increased feeling of hope, increased level of self esteem and self-confidence, a sense of purpose that they were making a difference in peoples' lives, and a sense of pride of being a positive role model amongst their communities.

The HIPS project and its evaluation experience highlighted many innovative and important lessons that can inform and inspire our collective work in reducing health inequities, advancing social justice, promoting access and fostering the building healthy communities. Please join us in this exciting learning journey.

Alan Li MD

Co-Founder Committee for Accessible AIDS Treatment (CAAT)

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1.0 Introduction

The Healthy Initiatives Promoting Safety (HIPS) project jointly developed by Street Health, the Regent Park Community Health Centre (RPCHC), Sistering, All Saints Church Community Centre and Sherbourne Health Centre. The HIPS project aims to mitigate risk and prevent HIV in a population of high-risk marginalized women and transgendered women (as defined by involvement in sex work and/or substance use) and women living with HIV in downtown Toronto, Ontario, Canada.

Street Health has been working in the East Downtown of Toronto for 27 years to improve the health and well-being of homeless and under-housed individuals by addressing the social determinants of health through programming, services, education and advocacy. Street Health's work focuses on the Dundas and Sherbourne neighbourhood, including the Regent Park Community. Similarly, Regent Park Community Health Centre (RPCHC) is a community based organization working in East Downtown Toronto for more than 40 years. The organization provides integrated primary health care services, health promotion services and community capacity building programs to reduce health inequities experienced by low-income, immigrant and refugee, non-status and marginally housed and homeless population. Both the organizations have a history of working with women engaged in street based sex work and also women using substances.

A needs assessment conducted in 2012 among street involved women by RPCHC and Street Health identified the need for HIV education and prevention and to address stigma associated with HIV/AIDS. The HIPS program was initiated with funding from the Mac AIDS Foundation as an intervention to reduce and prevent HIV risks among the marginalized women involved in sex work and or substance use and also women living with HIV in the downtown Toronto neighbourhoods.

Women engaged in sex work are at an elevated risk of contracting HIV because of unsafe sex practices. Studies have shown that also women injecting drugs are particularly vulnerable to HIV and Hep C as a result of shared use of injecting equipment. Sex workers and female injection drug users are particularly at risk because they engage in sex with multiple persons and also have intimate partners who use injection drugs (Astemborski *et al*., 1994; Gollub *et al*., 1998). Both these groups are not mutually exclusive in fact there is considerable overlap between sex workers and injection drug users (Jarlais & Semaan, 2005; Ditmore, 2013). Unsafe sex practices and drug use practices make them particularly vulnerable to HIV transmission (Spittal *et al*., 2002; Strathdee *et al*., 2001). Sharing of injecting equipment can lead to a rapid spread of HIV among users and unprotected sex between HIV –infected injecting drug users and their partners can spread HIV even further. Literature shows that women who inject drugs have particularly different needs and face higher risks of disease and level of violence

than men using injecting drugs. Since women injecting drugs are often perceived as contrary to socially constructed roles of women as mothers, partners and care takers, women drug users who are seen as opposed to this societal norms experience greater stigma and a range of specific harms than males (Roberts *et al*., 2010). Furthermore physical safety is one of the main concerns for street based sex workers. It is not uncommon for women street sex workers to be assaulted by predators, clients, pimps and in some instances the police. According to Lowman, violent and abusive clients prefer street based sex workers to sex workers in structured setting because of the anonymity factor (as cited in Maloney, 1995).The Ontario Women's Justice Network (2014) quoting a legal document stated that the murder rate for sex workers is estimated to be 60 to 120 times the murder rate of adult women in the general population. It is claimed that the violence experienced by sex workers increases their HIV risks. Women who experience violence feel stigmatized and have low self-esteem, resulting in diminished self-care, including HIV prevention, sometimes sex workers threatened by violence may prefer to avoid violence before avoiding HIV (Ditmore, 2013). Streets based sex workers using injecting drugs are doubly marginalized and discriminated and face many barriers accessing health care. Ditmore (2013) in her extensive review of sex work and women using injecting drugs remarks that the overlap between sex work and drug use is often overlooked while developing HIV and harm reduction policy and programmatic responses.

The World Drug Report 2014 estimates that 12.7 million people are using injecting drugs globally, among whom 1.7 million are living with HIV (13%). HIV prevalence among injecting drug users is more than 22 times higher than in the general population, and at least 50 times higher for 11 countries. An estimated 10% of all people who inject drugs worldwide reside in Canada and the United States however there is no disaggregated data at the gender level (Global State of Harm Reduction -2012). United Nations Office on Drugs and Crime (UNODC) in their 2014 policy brief state that though the proportion of women who use drugs is generally increasing there is not much data on women because most of the programs, services, surveillance on usage of injecting drugs is overwhelmingly gender neutral. There are currently no reliable estimates of the women who inject drugs. Injection drug use accounted for 17% of HIV cases in Canada at the end of 2008 whereas in some countries HIV prevalence among certain populations of injection drugs users has exceed 80% (Aceijas, Stimson, Hickman, & Rhodes, 2004). HIV and STI transmission among sex workers and women injecting drugs is a growing reality and currently the programmatic response to this issue remains woefully inadequate. The HIPS project intends to reduce and prevent HIV infections among street based sex working women and women involved in substance use using a peer based model that provides outreach and addresses their barriers to health care.

The HIPS intervention aims to reach out to the hard to reach street based sex workers and or those involved in substance use. The HIPS project thus aims to mitigate and prevent HIV risks by providing HIV prevention information, needle exchange, safer smoking kit distribution, and condom distribution to enhance safer sex and drug use practices. The HIPS project facilitates linking women to point of care testing enabling voluntary HIV

testing and counselling. Additionally the project also aims to connect women to support services according to their need thereby enhancing their access to health care. HIPS incorporated a peer based model which involved women with lived experience as sex workers who would be trained to provide outreach to the women in downtown Toronto.

This project evaluation is conducted to assess the effectiveness of the project in the light of the goals and objectives it set out to achieve and to analyze the lessons learned in helping to inform ongoing programming efforts to mitigate HIV risks among a marginalized and hard to reach population.

2.0 Literature Review

The concept of peer education is well documented in the field of HIV prevention as an effective method of relaying information and influencing behaviour change particularly within most-at-risk populations (Guarino, Deren, Mino, Kang, & Shedlin, 2010; Joint United Nations Programme on HIV/AIDS [UNAIDS], 1999; Latkin, Hua, & Davey, 2004). According to UNAIDS (1999), "peer education is a popular concept that implies an approach, a communication channel, a methodology, a philosophy, and a strategy" but a wide range of definitions and interpretations exist which outline who is considered to be a "peer" and what is considered to be "education" (Region of Waterloo Public Health, 2004; Shiner, 1999; UNAIDS, 1999, p. 5). When exploring the meaning of the word "peer" commonalities such as age, grade and/or status and shared experiences are often key factors that are used to define a peer but that definition can arguably be extended to any range of factors that help a group of people to identify with one another (Region of Waterloo Public Health, 2004; UNAIDS, 1999).

Just as there is much debate on what constitutes a peer, there is also a wide range of definitions and terminologies that are used to describe peer programs such as peer education, peer support, peer assistance and peer counseling, but according to Shiner (1999), there is a need to develop tighter definitions for these types of programs (Region of Waterloo Public Health, 2004). This will help to encourage greater consistency in the use of the terminology and also to ensure that everyone involved in developing and implementing peer programs, from organizational staff to funders and evaluators are clear on the objectives and outcomes of the programs (Shiner, 1999).

UNAIDS (1999) describes peer education as "the use of members of a given group to effect change among members of the same group" (p. 5-6). According to Mead, Hilton and Curtis (2001), "Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful…When people find affiliation with others they feel are "like" them, they feel a connection. This connection, or affiliation, is a deep, holistic understanding based on mutual experience where people are able to "be" with each other without the constraints of traditional (expert/patient) relationships" (p. 7). This is further supported by Shiner

(1999) who argues that the term "peer education" describes any intervention where the educator and the student are seen to share something that creates a kinship between them.

Peer education often acts at the individual level to effect change in a person's knowledge, attitudes, beliefs and/or behaviours through an interactive and participatory approach to learning (Shiner, 1999; UNAIDS, 1999). It can however, also act at the group or societal level by modifying norms and spurring collective action which can in turn lead to policy or programmatic change (UNAIDS, 1999). There are a number of behavioral theories, such as Fishbein and Ajzen's Theory of Reasoned Action and Everett Roger's Diffusion of Innovation Theory that provides a sound framework for peer education (UNAIDS, 1999). Albert Bandura's social cognitive theory points to the strong influence that social interaction has on behaviour change. This theory posits that people learn by observing others and beliefs about personal efficacy are critical to behaviour change because people are only motivated to act if they believe that their actions will produce the desired effects. Bandura suggests that people's beliefs about their efficacy is influenced by four main channels, "mastery experiences", whereby experience in overcoming obstacles helps to build an individual's sense of self-efficacy; "vicarious experiences" whereby when an individual sees someone similar to themselves succeed by sustained efforts, their own beliefs in their capabilities increase; "social persuasion"; and their own "somatic and emotional states" when judging their ability to adopt a prescribed action. In relation to peer education, vicarious experiences and social persuasion are most applicable. Bandura states that social models not only provide a social standard against which to judge one's own capabilities, but social models also serve to transfer knowledge and teach observers skills and strategies to effect change through their own behaviour and ways of thinking (Bandura, 1998). In a study conducted by Norr, Norr, McElmurry, Tlou, and Moeti (2004) among urban employed women in Botswana, it was found that a peer-led AIDS prevention intervention that incorporated social-cognitive learning to enhance self-efficacy, was highly effective in changing the women's knowledge, attitudes, beliefs and behaviours surrounding HIV prevention.

Other health promotion theories such as the Precaution Adoption Process model (PAPM) and the AIDS Risk Reduction model (ARRM) also point to the influence that social influences have on decision-making when it comes to health behaviours. Both of these stage theories point to the impact that social norms and the recommendations and opinions of others can have on a person's commitment to change and their ability to enact the desired change (Catania *et al*, 1990; MacKensie *et al*, 2009).

Peer-led interventions have several well-documented advantages. For one, they are typically less expensive to implement versus one-on-one interventions, they can often reach people who either do not frequent traditional health care facilities or who experience barriers in accessing appropriate and effective care, and peers are generally more familiar with the risks and concerns of the population in question (Latkin, Hua, & Davey, 2004). In addition, by providing social support, transferring knowledge about HIV and HIV prevention, influencing local development of new norms and values surrounding HIV prevention, teaching safer sex skills, and helping to increase self-

efficacy among individuals within the target population through rehearsal and role-modeling, peers can spur behavior change (Norr *et al*, 2004).

There are also several psychosocial benefits for the individuals who are trained as peer educators. For instance, in a study conducted by Grinstead, Comfort, McCartney, Koester, and Neilands (2008), participants in a peer-based HIV prevention intervention reported an increased sense of personal empowerment in their own romantic relationships. In a study conducted by Harris and Larsen (2007), peer educators described the work as rewarding and explained that it helped to give meaning to their own HIV diagnoses (as cited in Guarino *et al*, 2010).

As previously explained, peer-led interventions are particularly effective in reaching those individuals, especially vulnerable populations, who experience barriers accessing health care. One such vulnerable population, is sex workers who often experience social marginalization, criminalized work environments, homelessness, unemployment, poverty, violence, mental health issues and issues surrounding substance use or dependency. These circumstances, along with the fact that sex work in Canada is unregulated and heavily policed leading to high rates of violence, pimping and arrests, and the existence of several structural and individual level barriers affecting access to effective care, often leads to negative health outcomes in this population (Street Health and Regent Park Community Health Centre, 2014). In the case of sex workers who use drugs, aggressive policing and arrest has been shown to increase the potential risk of contracting HIV by encouraging longer working hours and increasing the potential for engaging in riskier sexual practices in order to compensate for lost income. Some sex workers may not carry condoms so as to avoid being identified as a sex worker (Ditmore, 2013). According to Ditmore (2011), sex workers worldwide are seen as a key target population in the fight against the spread of HIV not only due to their high levels of vulnerability to the disease but also because of the social and structural factors that further increase their vulnerability and act as barriers to accessing HIV prevention services.

Peer-led HIV prevention interventions targeting this vulnerable group have proven to be highly effective at eliciting behaviour change in this population. The Sonagachi Project, based in Calcutta, India, is arguably the most widely recognized successful HIV intervention and is used as a model for many peer-based HIV interventions that target sex workers specifically (Jana Basu, Rotheram, Borus, & Newman, 2004). The project, which actively engaged sex workers in various capacities including working as "peer outreach workers", targeted change at the community level, at the group level and at the individual level and has been sustained for over 12 years (Basu *et al*, 2004). Another such successful initiative was PSI Myanmar's Targeted Outreach Program (TOP), which implemented a strategic approach to HIV prevention among female sex workers in Myanmar by offering clinical services including HIV, STI and reproductive health services, and executing peer outreach activities, including education, dissemination of materials and community building. The TOP peers also invited potential clients to drop-ins, which were seen as a crucial component of the program. The

program saw great success in lowering HIV risk among sex workers and their clients not only because of the high level of coverage and the quality of the services that were offered but also due to the fact that female sex workers were included in both the design and implementation of the program. HIV prevalence rates among female sex workers who participated in the TOP program declined from 33.5 percent in 2006 to 11.2 percent in 2011 (Ditmore, 2011).

These programs serve as excellent examples of the success that can be achieved by utilizing a peer-based approach to HIV prevention among sex workers and other street involved women in downtown Toronto. In fact, the "Street Based Sex Workers Needs Assessment" conducted by Street Health and Regent Park Community Health Centre in 2014 recommended employing more peer workers as a means of helping sex workers to navigate and access health care and other social services (Street Health and Regent Park Community Health Centre, 2014). The connections and affiliations that can be fostered between the peers and individuals within this target group due to their shared experiences could potentially elicit behaviour change not only at the individual level, for both the clients and the peers themselves, but also at the community level and can help to build a strong sense of personal self-efficacy thus leading to improved health outcomes for this population. These connections are further strengthened when peer workers are hired for higher level positions where they have more input into program design and implementation (Ditmore, 2013). The literature clearly supports the use of a peer-based approach for HIV prevention and behaviour change among this vulnerable population however, studies assessing the link between a peer-based model of education and support to sex workers and access to point-of-care HIV testing and other health services, particularly in Toronto, are sparse. This study aims to fill this gap in the literature by evaluating the efficacy of a peer-based approach in increasing access to preventative health services among this high-risk population of sex workers.

3.0 The Healthy Initiatives Promoting Safety (HIPS) Project

3.1 The Context

Street Health and Regent Park Community Health Centre have been engaged in work with street sex workers and women involved in drug use for well over a decade. The Crack Users Program (CUP) implemented for crack cocaine users in downtown Toronto for both males and female users helped to provide an understanding of the specific issues faced by drug using women. To address some of the issues specific to women drug users, a women's only drop-in was organized for those using crack/cocaine and/or involved in sex work. RPCHC and Street Health later jointly developed a program called as the Safer Stroll Project to address the issue of violence which pervades the lives of street sex workers. Many of whom were living in constant fear of harassment, physical and sexual violence by clients, predators and arrests by police. The Safer Stroll project aimed to build the capacity of street involved women to deal with violence by sharing information

amongst themselves about 'bad dates' predators and developing a partnership with the law enforcement to apprehend violent clients. The HIPS project was developed in response to an identified need by women for HIV prevention education and reduction in HIV risks.

RPCHC and Street Health have been providing harm reduction services for drug users and sex workers in East Downtown Toronto. RPCHC data on the distribution of harm reduction stem kits and syringes over the last four years shows a clear shift in demand for injection drug kits as opposed to crack smoking stem kits. The demand for syringes from injection drug users has increased by 54% since April 2009 to March 2013. The distribution of syringes increased significantly in 2011 and has continued to be higher than the demand for stem kits. In fact the overall number of stem kits distributed has decreased in the year 2012-2013. This primarily shows that more drug users are injecting drugs versus smoking drugs. The increased use of injection drugs certainly has serious health implications. One of the significant findings of the harm reduction needs assessment conducted in 2012 was the prevalent stigma associated with injection drug use among drug users. Peer researchers collecting data noted the significant under reporting of injecting drug use because of the stigma linked to injection drug use (Out Of Harm's Way Report, 2012). This problem appears to be particularly true of women injection drug users because of the wide spread discrimination and stigmatization associated with injection drug use.

There is a rich body of literature which shows that street sex workers and women who inject drugs are at an increased risk of HIV and other sexually transmitted infections (STIs). The Toronto I-Track Report conducted by Public Health Agency of Canada (2012) shows that women are sharing more drug use equipment such as cookers and water, when compared to men, as well as not using condoms as frequently as men. The HIV and AIDS 2012 Surveillance Report notes that the majority (56%) of adult female AIDS cases were attributed to injection drug use (IDU). Overall, a higher proportion of adult females than adult males acquired HIV through IDU exposure 24.5% versus 10.9% (Public Health Agency of Canada). Data from the Toronto Community Health Profiles (2003-2007) also showed that HIV/AIDS was the third leading cause of premature mortality among Regent Park community members, behind heart disease and cancer, compared to the City of Toronto where HIV did not fall into the top 5 leading causes of death (Toronto Community Health Profiles Partnership, 2011). A study conducted in Vancouver and Montreal found an HIV prevalence of 29% for women involved in sex work (Spittal *et al*., 2003).

3.2 The Key Population

Sex workers are at an increased risk of HIV. Sex work is known to be a major independent risk factor for HIV (Kral *et al*., 2001). According to estimates female sex

workers are 13.5 more likely to be living with HIV as compared to other women (Baral *et al*., 2012). Similarly injecting drug users constitute a high risk group because of sharing contaminated needles. A combination of sex work and injection drug use increases HIV risks significantly. Female sex workers who inject drugs had 9.4 times HIV infection rates than female sex workers who did not inject drugs (Agarwal *et al.,* 1999). Sex workers and women injecting drugs are key populations in HIV prevention. The overlap between sex workers and women injecting drug users is currently overlooked in programming and policy development much to the detriment of these women.

A survey of street based sex workers conducted by RPCHC and Street Health in 2013 shows that 94 per cent used drugs, among whom the majority (75%) used on a regular basis (Street Health & RPCHC, 2013). There is a strong link between injection drug use and street based sex work. All sex workers do not use drugs, while for some drug use maybe independent of sex work, but for some sex work and drug use maybe intrinsically linked (Ditmore, 2013). Women may engage in what is known as transactional sex, i.e. exchange sex for money to buy drugs, while some women may engage in sex for housing and sustenance; engaging in sex work on a regular basis or occasionally all adds up to their HIV risks. Roberts, Mathers and Degenhardt (2010) rightly point out that not all women who inject drugs will identify as injection drug users and not all women who occasionally exchange sex for money will consider themselves as sex workers. The disparity between their risky behaviours and self-identification is critical and may in fact elevate their risk levels because they may not consider themselves as part of a risk group and thus excluded from any intervention (p.14).

Despite the acute need for healthcare and supportive programming for sex workers many continue to be underserved and experience barriers accessing care and HIV related services. The recent survey on street sex workers (2013) conducted by RPCHC and Street Health found that a significant proportion of the sex workers rate their health condition as poor and many do not have access to a regular doctor. Furthermore, less than a third of the sex workers mentioned that they always disclose their involvement in sex work to the health care provider because of the stigma related to sex work. The findings reveal the stigma associated with sex work often manifests in health care provider and sex worker interactions. Sex workers may avoid using the services and supports provided by agencies because they feel discriminated. Many experience problems accessing health services and do not have access to HIV testing or harm reduction kits. Often times sex workers delay or limit their interactions with health care providers to avoid judgmental situations. Due to a lack of focused programs many sex workers are unable to access health care and support services. In the Toronto region currently most of the harm reduction work with drug users has been focused primarily on adult males. Women drug users meanwhile remain underserved because of the inherent gender bias in programming. The lack of adequate targeted programming for women has resulted in the neglect of women drug users who remain unseen and isolated and socially marginalized.

3.3 The Project Description

3.3.1 Goal and objectives of the project

HIPS aimed to mitigate risk and prevent HIV in this high-risk population of women and transgendered women involved in sex work and or substance use and also the women living with HIV in the downtown Toronto area.

The project activities focused on outreach to the street based sex workers and drug users, the provision of HIV and prevention information and educational activities, enhancement of health practices and the reduction of HIV risks. Service users were to be provided with harm reduction supplies such as needle exchange, crack use kits, and condoms. The project specifically aimed to increase access to voluntary HIV testing and counselling besides connecting the sex workers to the different agencies, programs and services such as drop-ins and health care providers. The HIPS program was thus planned as an integrated model of care targeting a marginalized population with the following key objectives.

HIPS Program Objectives

1. Provide a safe, women only drop-in space for street sex workers organized by peer workers to help them meet other street involved women and to develop their own support networks and to provide HIV/AIDS prevention education

2. Train and develop peer sex workers to outreach to street involved women in the East Downtown Toronto area on a regular basis and provide safe drug use kits and condoms and other harm reduction materials to mitigate and prevent HIV

3. Provide HIV education and safe drug use education to street sex workers and equip street involved women with skills to practice safer sex and safer drug use.

4. Peer workers help increase accessibility and connect sex workers to voluntary HIV testing and counselling and a variety of programs, support services and facilitate access to health care to improve their health and prevent HIV transmission.

5. Peers train frontline workers in other agencies to work with street sex workers and or women engaged in drug use, and living with HIV to increase their access to services and programs both to internal and external organizational programs.

The HIPS project office was located at Regent Park CHC. In order to effectively outreach to the larger population of street based sex workers and women drug users the HIPS project developed some key partnership with the following agencies.

3.4 Objectives of the Evaluation

The purpose of this participatory evaluation was to develop an understanding of the peer model of programming, the supports they need as peer workers, lessons to be learnt from this project and whether or not peer outreach and support is effective at increasing access

to a continuum of health services among a high-risk population of sex workers. This process evaluation was also aimed at assessing project activities and ascertaining the extent to which the project met its objectives and the needs of the target groups.

This evaluation aimed to be an in-depth exploration of both the processes and outcomes of a peer model of outreach and support aimed at preventing HIV among women and transgendered women engaged in sex work. Specifically, in terms of outcomes we asked:

a) Does peer outreach increase the accessibility of point-of-care testing?
b) Does peer outreach provide a link to internal organizational programs?
c) Does peer outreach provide a link to external organizational programs?

In terms of processes the evaluation focused on the following aspects:

- What are the enablers of actualizing a peer-based model of outreach and support for this population?

- What barriers/challenges exist in actualizing a peer-based model of outreach and support for this population?

3.5 Partnerships

The partnership with The Works/Toronto Public Health was developed to help organize an integrated model of point of care testing (rapid HIV testing) for the HIPS clients in three different locations i.e. Sistering, Street Health and Regent Park CHC. The point of care testing was organized once a month in each location to facilitate HIV testing to help women become aware of their HIV status. The Works also provided counselling services to the women using the point of care testing. Partnership with the different agencies was developed primarily to help women from the different neighbourhoods to access care and services. Proximity to services such as drop-ins is crucial while outreaching to street involved women because they do not have the time or resources to travel across the city to access services. These agencies were already connected and had established links with the street based sex workers and drug using population

i) The Works, an agency (of Toronto Public Health), which provides point of care testing for clients and counselling services in different locations, besides providing services to individuals who use drugs.

ii) Sistering, a not for profit agency serving homeless, low-income and marginalized women in the west end in Toronto

iii) All Saints Church Community Centre located in East Downtown Toronto neighbourhood provides a drop-in program for women and transgendered engaged in sex work

iv) Sherbourne Health Centre works with a diverse population and provides primary health care services, a health bus outreach program which provides health services to homeless and under-housed clients in the downtown area, and a weekly drop-in program for women engaged in sex work.

3.6 Peer Workers

The intervention was developed as a peer driven initiative providing low barrier services such as outreach to sex workers and injecting drug users in Toronto. The HIPS project is facilitated by a Project Coordinator and four peer workers who form the core of the team. The peers were to engage street based sex workers, provide HIV prevention education and promote safer sex practices and connect them to the point of care testing clinics. In addition the peers also provide the women with harm reduction tools such as condoms and sterile drug use kits. The project also set out to facilitate access to voluntary HIV point of care testing and counselling to help women become aware of their HIV status. HIPS Peer workers were recruited from each partner agency. The peer workers are women with lived experience and are familiar with the issues concerning street based sex workers and women using drugs. The peer workers are also intimately familiar with the community and street sex worker population.

All the peer workers engaged in the project were employed on a part time basis, roughly 6 hours per week. Outreach activities included providing community information and referrals to programs and resources available through HIPS partner agencies and external agencies. The peer workers were trained on HIV/AIDS prevention with the help of Toronto People with AIDS Foundation (PWA). Additionally, training was also provided to the peers in community outreach, communication skills, maintaining boundaries at work, and harm reduction. A peer based model was used as a strategy to help women develop a sense of ownership of the program and also to enhance its effectiveness because peers with lived experience have the knowledge and skills to connect to street based sex workers. The peers' roles included working with frontline staff from different agencies to help them promote and increase access for sex workers and drug users.

3.7 Women's Drop-in Program

Almost all the partner agencies involved in the HIPS project provided space for the peers to engage in educational activities for the women. All Saints Church Community Centre, Regent Park CHC, Sherbourne Health Centre and Sistering had a Drop-in program for women. The drop-in programs were chosen for the intervention because they were identified as active hubs frequented by women, inclusive of transgendered women engaged in sex work. The drop-in programs provided participants with integrated care that included access to food, laundry, and shower, access to health care besides other services such as housing support, social workers and referrals to other agencies. Thereby women accessing these drop-in programs could avail a host of other services. Most importantly, women using the drop-ins could get to meet other women in similar circumstances in an informal setting and develop their own support networks. The peer workers role included facilitating the drop-in programs on a weekly basis.

A peer model was thought to enhance the project's capacity to establish connection and trust among street based sex workers. This intervention was also thought to further develop networks within the community that addressed safety issues. Peers were engaged to help women break out of their isolation and marginalization by connecting them to different agencies and services. The peers were to be the role models to sex workers and women using drugs. This project implemented on modest resources was to be a model for engaging peers in this key role as the agents of change. The evaluation of the HIPS project was conducted using a participatory process.

Peer work in the HIPS project includes the following key components:

i) Peer workers provide HIV prevention workshops to sex workers, women who use drugs and frontline staff of agencies in the neighbourhood.

ii) Peer workers provide outreach to various communities across the GTA to provide HIV/AIDS prevention education and support to women engaged in sex work and/or substance use. They provide injection safer drug use kits and safer smoking kits, inform people about HIV testing, provide referrals and distribute condom wallets (which contain a bad date booklet, condoms and a list of services for sex workers).

iii) Enhance Women's Drop-ins at Regent Park Community Health Centre, All Saints Community Centre and Sherbourne Health Centre with peer workers and provide support to women to increase access to health care, and support services such as housing, food, and referrals

iv) Provide access to voluntary HIV testing for women (point of care testing POC) through an existing partnership with the City of Toronto Public Health's harm reduction program: The Works.

The HIPS project planned targeted interventions to inform street based sex working women about the HIV risks they may engage in, and steps they could take to prevent HIV by changing their sexual and drug use practices.

4.0 Methodology

This evaluation utilized a mixed method approach for data collection. Both qualitative and quantitative methods were employed in order to get a good understanding of the processes involved in the project. The evaluation followed a participatory process which involved engaging peer workers in the evaluation of the project and also organizing an Evaluation Advisory Committee. This committee comprising of various community and organizational stakeholders was formed to provide guidance and feedback throughout the evaluation process. The peer workers and other collaborating

partners where involved in development of the program evaluation objectives. Four peer researchers were recruited to assist in the design of the data collection tools and the collection of data. The peers were trained in collecting data and the methodologies that were employed for the research. The research evaluation project also got ethics approval from the Centre for Community Based Research; Community Research Ethics Board (CREO).

4.1 Qualitative data

In-depth Interviews

The qualitative data for the evaluation was collected using in-depth interviews and focus groups. Interviews were conducted with clients who accessed HIV point of care testing. The peer workers were also interviewed in-depth for the evaluation using a structured interview schedule. In addition to this two focus groups were conducted, with the key informants from different agencies working with the HIPS project and another focus group was conducted with the peer workers.

The peer researchers conducted a total of 8 interviews with clients who accessed point-of-care testing. These interviews were aimed at gaining a better understanding of the health care needs of clients and their access to resources within the community, their understanding of the work of peer worker, their experiences interacting with the peer workers and the impact that the peer workers may or may not have had on their decisions to access point-of-care testing and other programs. Care was taken to ensure that the peer researchers did not conduct interviews with clients that they had direct contact with in their roles as peer workers so as to reduce the opportunity for interviewer and participant bias.

Semi-structured interviews were also conducted with the peer workers and these interviews focused on the role of peers as understood by the peer workers themselves, their experiences of being a peer worker, their interactions with the clients, the successes, challenges and rewards that they experience in their roles and their feedback for the improvement of the HIPS program.

All of the interviews were recorded and transcribed by an external consultant and all identifying information was removed from the transcript so as to protect the identity of the participants.

Focus Groups

Two focus group sessions were conducted with each lasting for approximately 1 hour. The first focus group consisted of four key informants, specifically individuals who were managing the program at each of the sites and therefore had extensive knowledge of the HIPS project and could provide insight into the preparation and support

that was provided to the peers for the duration of the program, the impact of the project and the successes and challenges faced.

The second focus group that was conducted consisted of the peer workers and took the form of a visioning session that focused on their personal growth as peer workers, the rewards and challenges associated with their roles and their vision for the future of the project and peer work as a whole.

4.2 Quantitative data

Client Surveys

The evaluation collected quantitative data using a survey form. These survey forms were given to 30 clients to get their feedback. The sample was randomly selected during the HIV point-of-care testing clinics, which took place at the partner organizations during the data collection period. The peer researchers used random sampling to recruit participants who included women and trans-women that attended the clinic and got tested for HIV. These women were approached by the peer researcher after they received their HIV test and asked if they would be willing to complete the survey. All the clients were provided with a consent form to read which explained the purpose of the project, what they will be asked to do, risks and discomforts, benefits of the research, their voluntary participation and confidentiality. Only clients who were able to provide free and informed consent were surveyed.

The survey consisted of a mix of quantitative and qualitative questions, which included some demographic data as well as questions pertaining to accessibility to services and resources within the community and the impact of peer workers on accessibility. Participants had an option to either complete the survey on their own or with assistance from the peer researchers. The responses were recorded by hand directly on the questionnaire. Persons completing the survey received $15 as compensation for their participation.

5.0 Findings

The study sample comprised a total of 45 respondents among whom 30 were clients who had used the services provided by the peer workers, participated in the survey in addition to which 8 other clients participated in an interview. In depth interviews were conducted with 3 peer workers and also a focus group and 4 staff members from different agencies who were involved in the HIPS program participated as the key informants in a focus group. A demographic profile of all the survey participants is attached. (Appendix B)

The thirty clients who participated in the survey were selected from different partner agencies participating in the HIPS project and similarly the eight clients interviewed about their experience with the HIPS project and the peer workers in particular were from different agencies. All the peer workers were also interviewed in-depth about their experience working as a peer. Lastly, agency staff persons working with peers in the different drop-ins participated in a focus group as key informants. In addition to this source of information project records, training materials were perused to get an understanding of the project activities.

There are a number of limitations that need to be taken into consideration with the evaluation. A major limitation is that the results may not be generalizable to the entire population of sex workers in downtown Toronto due to the fact that the sample size was relatively small and also because the participants were only recruited at the project sites.

Time and financial constraints also presented an issue for participant recruitment. The evaluation budget was limited and therefore restricted the number of participants that could be recruited and compensated for their participation in the study. In addition, the timeframe allotted for conducting the evaluation also limited the number of participants that could be recruited. Another limitation that presented an issue for effectively assessing the effectiveness of the program is the fact that the number of HIV tests that could be performed on a given day during the point-of-care clinics was based on the capacity of Public Health staff from the Works to perform the tests during the drop-in time period. The Works staff were usually only able to test a limited number of women during the given time period for each point-of-care clinic and so it is difficult to determine if more women could have been tested throughout the duration of the project if more testing slots were available.

The final limitation that needs to be considered is researcher and participant bias. The HIPS peer workers were recruited as peer researchers and so a degree of personal bias may present a limitation for the study. In an effort to mitigate this limitation, extra care was taken to ensure that the peer researchers did not interview any clients whom they may have provided support to in their role as a peer worker. It is important to note that building trust within this population is very difficult and so the peer workers were best suited to recruit participants and conduct the semi-structured interviews with the clients. Their ability to easily build rapport with the study participants possibly provided a higher

level of comfort for them allowing for more open dialogue. Therefore this limitation could also be seen as a research strength and it was acknowledged and monitored throughout the data collection process.

The data from the surveys, interviews and focus groups are used in this section and specific reference to the survey data or focus group or the group interviewed is only mentioned where relevant.

Defining the term "peer worker" in the context of the project

The qualitative data obtained during the interviews and the focus groups revealed an understanding of the term "peer worker" among the clients, peers and key informants (staff members working on the HIPS project from the different agencies). Most of the respondents felt that a "peer' constitutes a person with lived experience who is there to provide support and outreach to members of the target population. Of the clients that were interviewed, the vast majority demonstrated a general understanding of the term "peer". A client when asked about the peer workers commented,

> At first I didn't know what's a peer….. I had no idea who they were. But now it's like ….the person that you don't even know but once you talk to them once, you understand that you can communicate with them and actually relate to them in so many different ways like lifestyles, living arrangements, growing up life, drug use, sex work, all of that. …it's good that you can actually just come to someone and be like 'can you help me figure out how to do this or I just need some support right now' or just anything and they're there for you.

One client described that a peer was like a "lifeline" while another explained a peer as "someone on equal terms to me, someone that's had shared experiences that I have." Only one client indicated that they did not know what the word "peer" meant. Several clients mentioned that peer workers were non-judgmental and this quality appeared to be an important element in helping peers to be successful in outreaching to the key population groups.

All of the peer workers stated that they felt that a "peer" is someone with lived experience. One respondent presented a very clear definition for a peer,

> It means someone with lived experience, someone who's lived a life on the streets, someone who's done drugs, someone who's been involved in prostitution, who's been arrested. When I hear the word peer that's what comes to mind.

While discussing peer workers the key informants indicated that the peers were approachable and that clients were able to be "extremely open" about their drug use and sexual behaviours in a way that they probably would not have if they were speaking to service provider. They also acknowledged that the peers bring many skills and a great deal of knowledge to the role through their lived experiences.

The clients, program staff, and peers themselves have a shared understanding of the term peer. Peers were seen as bridges between the user and deliverer of services and they were seen to normalize the experience of the service user because of shared experiences which made the peers trustworthy among service users.

On the other hand a peer worker had some reservations about the job title as peer worker. While discussing her job title she mentioned,

> I think initially when I started before the HIPS program the word peer didn't bother me so much. I don't think I completely understood what it represented and what it meant… It really creates a barrier between peers and staff, like one is higher than the other, hierarchy sort of…As soon as you attach 'peer' to your position people are automatically assuming that you have lived experience and that's not for other people to guess or to put on you. It's your own journey and story. So it's up to us to sort of out ourselves and the word peer does that for you. I'm not a big fan of the word peer.

This sentiment was also expressed by the key informants. They mentioned that there are struggles with peers about the title of being a peer especially because some of them felt that the title peer worker differentiated them from the rest of the staff in the agency and hence they felt like they were at the bottom of the totem pole. Though the key informants reassure the peers that they were an integral part of the team, they felt that more support was need for the peers.

In a related point a peer worker observed that agency staff can make or break a peers' experience. If they don't fully understand what the peer position is, it could be very oppressive. However if all the agency staff are on board it can be very empowering for the peer worker, thus it is important to acknowledge and support the role of peer workers.

Training and Support

The qualitative data from peer interviews reveal that peers receive on-going training and support throughout the duration of the program. The peer workers are provided intensive training before they commence their duties. The training helps to remove misconceptions that they may have had about HIV and sexual practices which may expose a person to HIV. They were also trained about unsafe drug use practices, and risks involved with sharing needles and other equipment. Project documents show that evaluations were done after every training session to gauge their increase in knowledge. Peers are also trained in community outreach by the outreach staff and taken around the neighbourhood. Peer workers were familiar with the places frequented by sex workers and drug users since the peers are mostly from the local community.

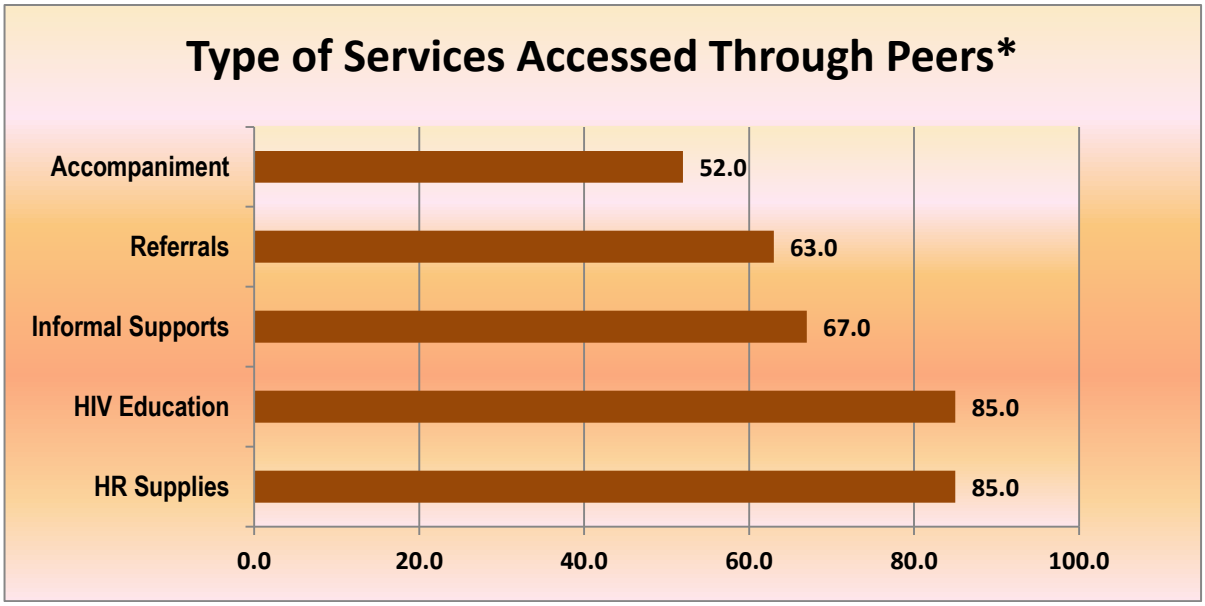
One of the peers indicated that it would have been more helpful if the peers had been consulted when designing the training curriculum in order to ensure that it was not repetitive for them and to ensure that the training was better tailored to their needs. All of the peers felt that the training that they received on boundaries was very helpful for them. One of the peer workers observed "the one thing that touched me was boundaries…I thought that's a skill that I didn't have…to this day I still go over my notes that he provided on that because it's so important to keep your boundaries".

In terms of support to the peers, one key informant, supervising peer workers explained that if the peers required any support or clarification they could discuss and get help because the peers were seen on a regular basis. She explained that they debrief about their work and their lives and if their work is impacting on their lives, they deal with the issues right away. The peers are also provided feedback on their performance on an ongoing basis.

5.1 Access to Services

One of the main objectives of the project is to increase access to street based sex workers and women drug users to harm reduction services, providing HIV education and promoting voluntary HIV testing and counselling besides connecting women to other resources such as health care, housing and detox services.

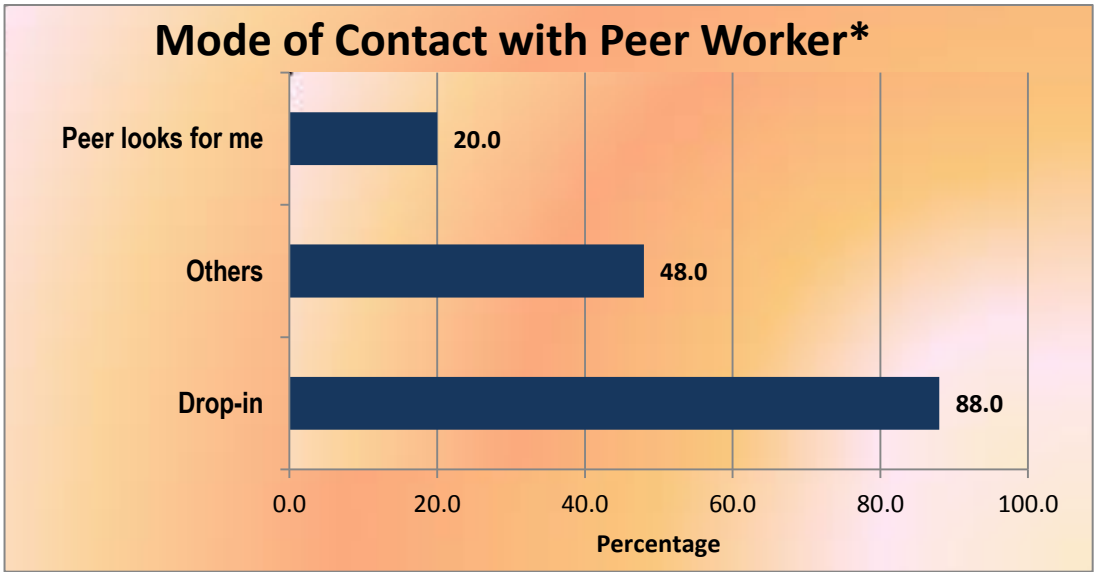
Chart.1



The above chart shows the different types of services that street based sex workers and women drug users access through peers. The vast majority of the women (85%) mentioned HIV education and (85%) harm reduction supplies. More than half of the respondents indicated that they accessed informal supports, referrals and accompaniment services. This clearly shows that peer workers efforts in engaging sex workers to mitigate and prevent HIV risk is certainly working. Peers workers have been engaged in outreach to sex workers and women involved in drug use for almost a year before this data was collected. Peers mentioned that the demand for the harm reduction kits and condoms has increased steadily over the period of time. The regular outreach rounds to meet sex workers and engaging them in informal discussions has helped peer workers to build trust and also to encourage sex workers to use harm reduction supplies.

Peer workers also provide different type of support services to their clients in order to build the relationship with the street based sex workers though this is not part of their defined roles i.e. helping to get new ID, to access housing, open a bank account; accompany them to the hospital because the women are often isolated and peers connect the women to the different agencies for support. (See Appendix A for outreach data).

Chart.2

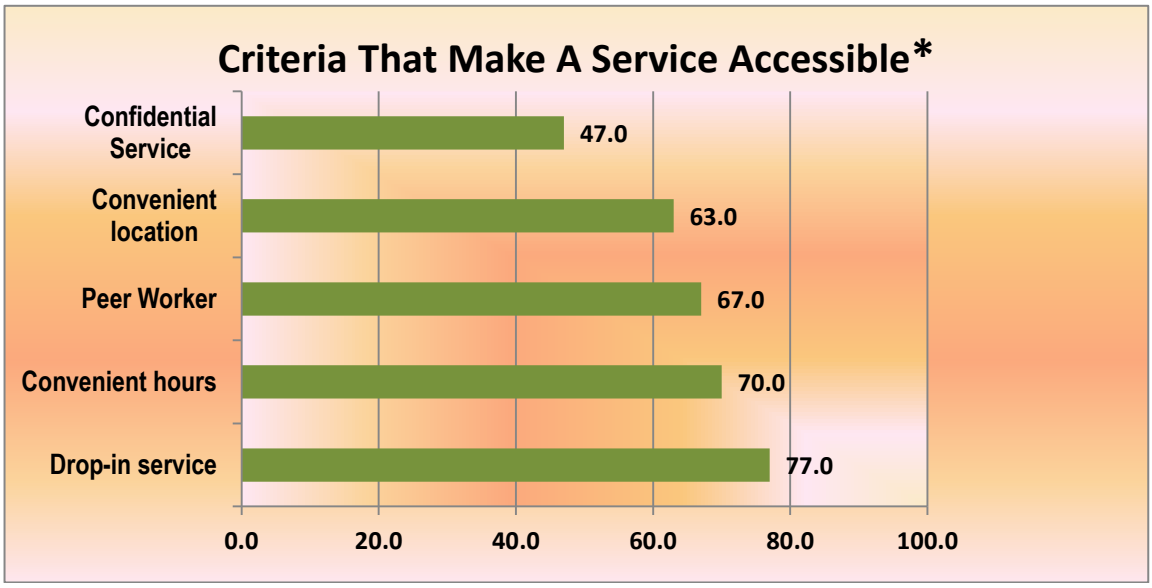


***Multiple Responses**

Chart.2 showing the most common modes of contact between clients and peers

Clients were asked how they get hold of the peer workers to see if they know where to find a peer worker and what works for the clients especially if they are in a crisis and need the assistance of a peer worker to access an agency or a service. The majority mentioned the drop-in because the peers are always there at the drop-in to meet the women and the connection to the drop-in for many women is through the outreach done by the peer workers. Peers are also in touch with their client through other means such as telephone; through other staff at the agencies and also through casual contact.

Chart.3



*Multiple Responses

With regards to service accessibility, survey respondents indicated that drop-in services (77%), convenient hours (70%) and a peer worker (67%) were the three most important criteria that make a service accessible.

The evaluation reviewed the processes involved in promoting access to services for sex workers and drug users. The drop-ins organized in the different agencies serve as the focal point of access for street sex workers. They key partnerships developed with the partner agencies help to increase access to the women located in different neighbourhoods. All the peer workers connect women to the different drop–in programs so that they can access the services in their neighbourhoods.

The Drop-in programs function as a women only space providing a low threshold service for women and trans women once a week in different locations. The term low threshold means a consciously maintained expectation of behaviour that ensures as few women as possible are denied access to services, regardless of their presentation: agitated, high, coming down from a substance, etc. Non-judgmental approaches are applied and each woman's experience and situation is understood within a context and seen as unique. The women and trans-women only drop-ins strive to be inclusive of all marginalized women. A peer mentioned that sometimes women are "on the run" for a week (high on drugs) and when they come to the drop-in; they are stressed out they have no sleep or food and they can be restless and unsocial. Peer workers and staff help all women to use the space and respect each other while at the drop-in. The women's drop-in attempts to cater to all women. There is a couch to rest, a computer with internet access, food and coffee. Sex workers could use these spaces on a specified day of the week and meet a peer worker in an informal environment and also access services of a social

worker or a nurse without any prior appointment. The women utilizing the drop-in could also meet the peer worker in private room if required for a confidential consultation.

Additionally, women could use laundry and shower during this time. They also have access to health care services, where they could see a nurse or social worker or get housing support and referrals to other agencies or services. Thereby women accessing these drop-ins could avail multiple services without prior appointments. More importantly women using the drop-ins could get to meet other women in similar circumstances in an informal setting and develop their own support networks.

Furthermore, peers also conducted workshops in the agencies for staff persons about their work and the HIPS project. This was done to help frontline staff to be aware of the project and its objectives and also to create a welcoming environment for the clients visiting the centre.

HIV Education and Reduction of Risks

The Drop-in programs are the focal point wherein peer workers engaged sex workers in HIV education and methods to prevent and reduce HIV risks. As the peers mentioned earlier the interaction with the women on the street and public places are not always the ideal locations for providing HIV information. The women connected to the drop-in are provided with the space and an environment suitable for providing the information and developing awareness of the risks involved in sex work and injecting drug use. Peers conduct workshops and information sessions on HIV/AIDS, harm reduction practices in the drop-ins.

When respondents were asked about HIV prevention education provided by peers, the majority of the clients (70%) interviewed indicated that they were more comfortable being taught about safe sex and HIV prevention from a peer as opposed to a health care professional. A key informant observed that she never had so much "HIV information in her face before in a really great way", the peer workers were very approachable and that made a difference. Clients mentioned that they felt embarrassed when they go to a doctor or a nurse to ask about HIV prevention and they don't often mention their involvement in sex work. The peer workers lived experience helps them to fully understand the issues which make the practice of safe sex onerous at times. Peer workers while discussing safe sex practices with sex workers provide guidance on how to negotiate condom use with a client. This is often a difficult task and condom use is not always a straightforward process. One of the peer workers observed;

> When you're out there and you're hustling a buck on the street and you get in the car, you've got condoms on you. If that guy isn't going to put it on and you need that money, you're going to do whatever you've got to do alright…. But the bottom line is… often times a guy will have problems maintaining an erection even while

> trying to apply a condom. So you'll do it anyway without it. This is a very hard cold fact of sex worker. It's a little easier when you're working in a house and you have a steady clientele. These guys know you and they know you're not going to do it without one and you hone your clientele so that these are the only clients that you deal with. But it's quite different on the street because it's desperation. It's not comfortable. You're not in your home and he knows your deal. It's a completely different way of doing business and it's very desperate. So all the teaching in the world isn't going to change that fact. ….The girl knows but she needs that bit of money so badly that she's got no choice. She's going to do it. So rather than beat her around the head for that, promoting things like the female condoms, of course if you're going to have intercourse.

The observation by a peer worker shows that they are keenly aware of what works and what may not work in a situation and hence are able to offer different scenarios to sex workers to prevent HIV such as using a female condom.

The peer and client interviews reveal that sex workers are not always aware of HIV risks in sex work and injection drug use. The discussions also show that there are several misconceptions about HIV because of lack of information.

Clients were asked if they had got HIV education from the peers and how that has changed their health practices. The responses from clients show that they have certainly increased their knowledge on HIV and risks involved in unsafe sex and drug use practices and have changed their practices. A client commented in this regard,

> I heard of a female condom but looking at the package, I'm like how … do you put that in there. It kind of looks like a tampon but it doesn't make sense to me. The peer fully showed me not like on herself but on her hand and she showed me how to insert. I'm like well that makes more sense. Even the dental dam, she showed me that because you can still catch it if you have broken sores. Blood just has to connect right. So I didn't know all that. So just getting that information made me more aware of how risky I put myself into because I was high and I really didn't think it was a risk.

Another client's comment adds more light, "I've learned ways to protect myself. I've learned about harm reduction about not sharing any tools or use condom all the time and

just more self-protection really." In some instances clients don't know the locations where safe sex and safe drug use supplies are available and information on how to practice safe drug use. The misconception about oral sex and HIV appears to be quite common according to the peers, this sex worker's statement also shows this popular misconception;

> I remember I used to think it was okay to do oral without a condom and I'm like you can still catch something, not exactly HIV at the exact of doing it but at the end impact of it you can still catch it if I have a cut and he has a cut. It's still there. I didn't know that that was bad.

Talking to the peer workers helps clients learn a lot of things besides HIV prevention. The lived experience of the peers certainly provides them with the knowledge and skills to make the connection with the sex workers. This comment from a client provides some insight into the one on one discussion with their clients;

> I learned a lot from peers like where to put your money and hide it. I learned that one. Definitely do not …. without a condom. I learned that. I said 'why, you can't get nothing from that.' Oh yes you can. I didn't know that. So I've learned that too. I'm looking at the dates on the condoms. I never looked before. I'm starting to look at that now, the dates on the condoms. I didn't know that.

The peer workers mentioned that the amount of condoms they now carry in their outreach has increased over the time. One of the peer workers commented in this regard "So I know women that have never asked for them will actually come and say to me can I have some or even the women condoms which wasn't happening at the beginning."

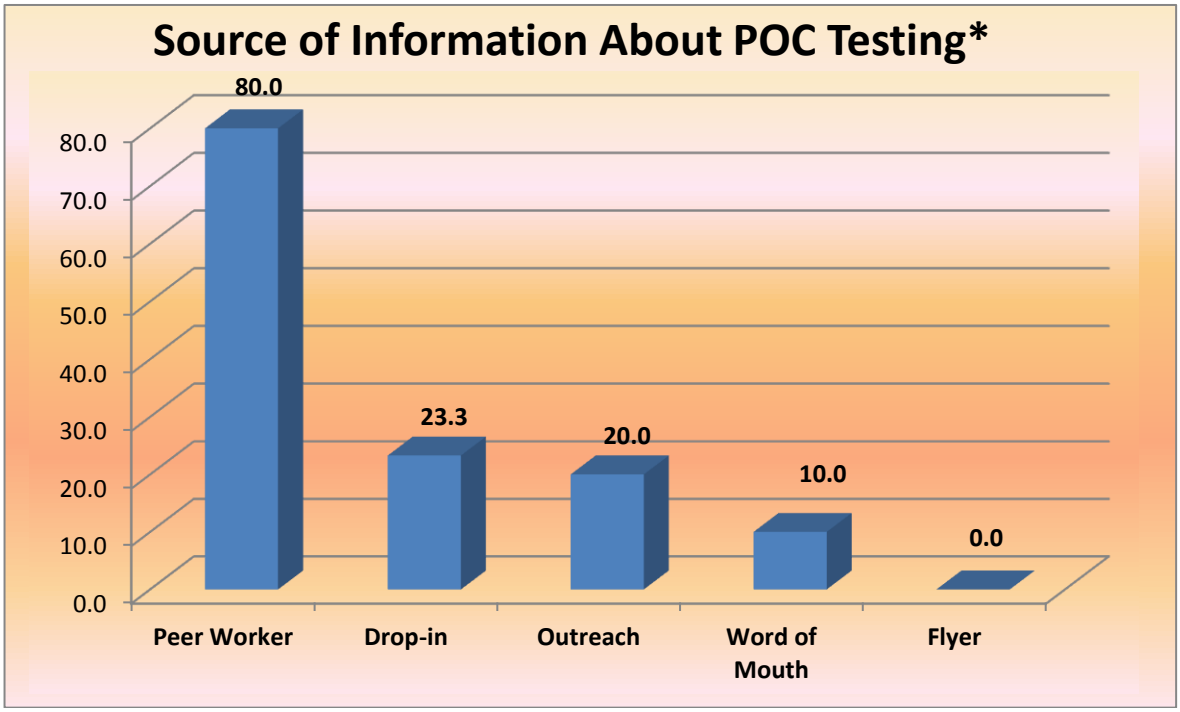
Voluntary HIV testing

All the peers were asked to connect the sex workers and women drug users to the point of care (POC) HIV testing centres. The partnership with Public Health Toronto agency called The Works provided HIV testing and counselling at the different project sites, i.e. Regent Park CHC, Sistering and Street Health. The peer workers usually refer women to the nearest POC testing site depending on their specific location. Peers actively promoted the testing among the key population groups in order to help them know their current HIV status. Clients voluntarily doing the HIV test are helped to know their HIV status and thus will reduce their HIV risk practices by using safe drug use kits or use condoms more often. The testing is facilitated by the peers in the different sites and there is a nurse who conducts the actual testing. The client gets her result in a short while and it is totally confidential service. The POC testing is actively promoted by the project because there is a fixed amount of time during which the testing could be done, so the peers had to organize the women to be available on the specific day and time to utilize the available

time optimally. The Works has limited staff and they only offer POC testing to be done once a month in each site.

All the clients using the POC testing were asked how they came to know about the voluntary testing and counselling service to help track the client's source of information of the POC testing site. This data was collected to help determine ways of communicating with the key population groups. Prior to the POC HIV testing, flyers were posted across the agencies and agency frontline staff were informed about the POC testing dates and venues.

Chart.4



*Multiple Responses

Chart.4 showing the sources of information about point-of-care testing for HIV

The findings show that most of the clients heard about point-of-care HIV testing through a peer worker. This was further supported by the qualitative data collected through the client interviews. Of the clients that were interviewed, 90 percent indicated that the information and support provided by the peer workers directly influenced their decision to access POC testing. Over 40 percent heard about POC at either a drop-in or during outreach, which are also linked to the peer workers as seen in Chart.2 demonstrates that the most common mode of contact between clients and peers occurs during drop-in programming.

The qualitative data also demonstrated the link between the peers and POC testing. One key informant indicated,

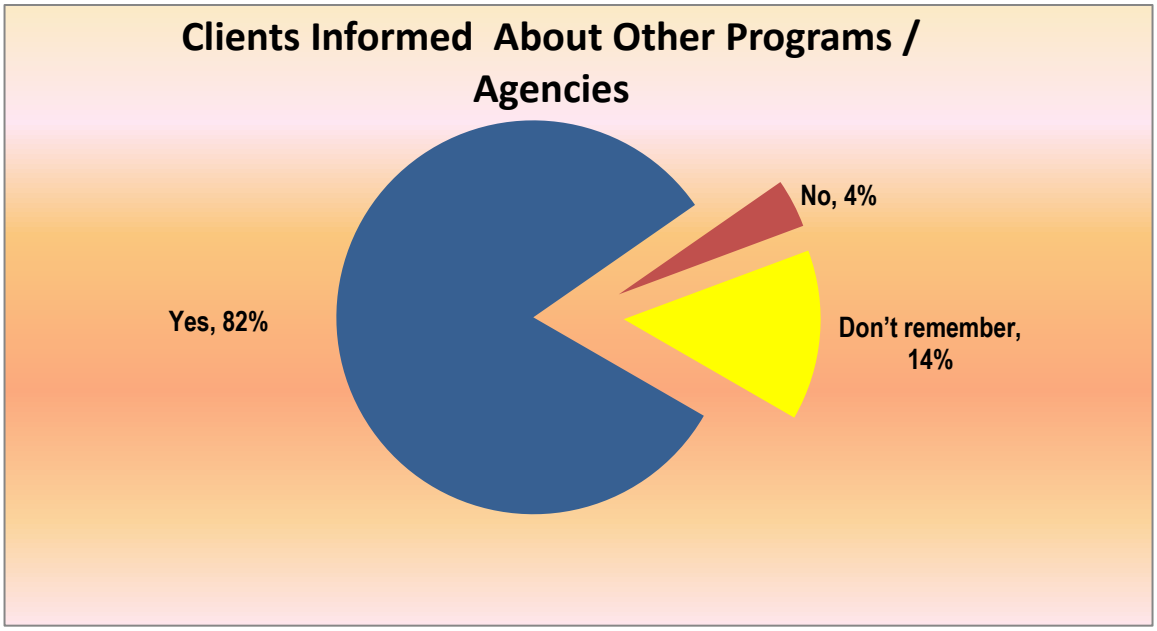
> It's on site and clients that would normally just come anyway to the place now have full access right there and then. So I think it really addresses a need that otherwise they may not go out and do and pursue somewhere else. They may not go to Hassle Free Clinic. But if it's right there in front of them they're going to get it done.

A review of the program statistics for POC testing shows that on average 25 to 30 women got tested each month at POC sites. The key informants mentioned that the peers have been able to bring in many street sex workers to access the POC HIV testing service. A key informant pointed out that, "We have been fully booked…we never have a spot open." Furthermore, key informants also indicated that there has been an increase in the number of clients accessing other organizational services, particularly the drop-ins as one of the key informant stated, "[Clients] might not even have known about the drop-in if the peer hadn't been out there." They felt that peers help reduce the stigma of getting tested. ..they normalized it". While discussing voluntary POC HIV testing a key informant mentioned that the peer worker co-facilitating the drop-ins helped to bring in many street sex workers that she had relationships with in the past, many of whom would probably not have turned up if she was not there.

One of the major problems of street sex workers is the isolation that most encounter in their daily lives; being connected to a peer worker will help them to connect to the drop-in or access services when required. An essential part of the peer workers role is to inform women and to help them access the different programs and services provided by the HIPS partner agencies and external agencies/ services such as detox centres, shelters, food banks, AIDS agencies and housing providers. The women can thus access health care and also get other services leading to improved access and health.

The survey findings also illustrated that peer workers also serve to link clients to other internal and external organizational programs as seen in Chart.5

Chart.5



Over 80 percent of clients indicated that they were informed about other internal and external programs. A review of the outreach statistics indicated that over 270 women received referrals to internal programs and over 150 women received referrals to external programs.

When peers were asked about the referrals provided to their clients they mentioned several examples of connecting women with housing workers and they were able to get housing, a woman with Hep C was connected to a health care provider. This comment shows the links to services which peers are able to make for clients.

> I've been able to escort five, possible six women to People With AIDS Agency. They didn't even know it existed which was a big eye opening for me that …… women that are street involved and walking these very streets don't know. PWA is right around the corner from WINK (Women in Need Klinic) and no one knew that it was there and the services that they offer going and then also for the client to have enough respect in me to hold her information and wanting me to escort for the first intake, which is scary. That was huge. It showed me that I'm doing what I'm supposed to be doing properly.

Many respondents mentioned informal supports provided by the peer workers, the supports provided are varied in nature. These findings were further supported by qualitative data one of the interviewed clients mentioned,

> Peers have helped me in like different aspects of my life. For instance when I was pregnant one peer is like 'you need to get out of this house, it's not safe for you, you're not going to sleep properly, they're eating your food, you're still using but you can go to a drop-in or a shelter that can better help with your pregnancy.

Another client pointed to the connection and referrals that peers provide to other external organizations,

> That's another thing; if you're having problems with your landlord, they can get you in touch with organizations that you're not aware of or even if you are. Organizations that help people seem to be able to get through to these other organizations a lot easier than me walking in off the street and say I need help. They'll call up and say this woman needs help and this person needs help.

5.2 Role of the Peer Workers

The qualitative data collected from the interviews conducted with the peer workers and key informants (persons who supervised peers in the different project sites) reveals that the peers' roles were extensive and varied.

Peer workers helped to develop the project outreach materials such as the community resource booklet. The small pocket size booklet contains information about resources such as rapid HIV testing centre, AIDS agencies, rape crisis centres, detox centres, food banks, HepC clinics, clothing banks, shelters, health care access, ID clinics, sex workers drop-ins programs, legal clinics and other places which street women may want to access. Peers also helped to design a condom pouch with important information for the women to use when needed. The peers developed the outreach material such as flyers for the HIPS project.

Peer workers did outreach to the sex workers and drug users in downtown neighbourhood, and help enhance the women's drop-in at different agencies partnering with the HIPS project. Peer workers also help clients and facilitate HIV testing at the Point of Care (POC) testing centres. Peers provide harm reduction supplies to clients visiting the Health Centre as a measure to encourage more women drug users to access, condoms and harm reduction kits. Additionally, peers were also engaged in HIV/AIDS educational activities, staffing tables at drop-in programs that offered information,

condoms and skill building for safer sex and drug use. Peer workers also went out with the Sherbourne Health Bus operating in the night and early morning providing harm reduction supplies to sex workers across the city.

Outreach to street sex workers and women drug users is one of the primary roles in their work. Peer workers walk around downtown Toronto East end spots frequented by street sex workers, distributing harm reduction supplies, i.e. crack kits, sterile injection kits, condom pouches besides socks, soap, and the bad date and resource booklet for street women. They meet street women in their work environment on a one to one basis. The outreach is usually done in late evenings when women are usually setting out to work. Outreach conducted with the Sherbourne Health bus covers a larger area of the East and West Toronto, the Health bus visits spots frequented by street sex workers. The Health bus follows a specific time table so clients are aware of bus timings and services. The Health bus is accessible to sex workers because peer workers provide the services and its timings to specific neighbourhoods (ranging from late night to 5am in the morning) to correspond with the sex workers' work schedule. Providing sterile injection kits and other safe drug use supplies at their worksite is important because street based sex workers who inject in their worksite often tend to reuse syringes and other drug paraphernalia increasing their HIV risks.

When asked about providing HIV prevention information to street sex workers, peer workers mentioned that at the drop-ins located at Sherbourne Health Centre, Sistering and All Saints Church Community Centre they organized a table with information about harm reduction /HIV. Women at the drop-in could meet the peer worker and get information about HIV and clarify any doubts they may have. This resource was used well by many women at the drop-ins. Additionally during street outreach they provide information on HIV and the importance of using sterile needles and condoms to reduce risks. However providing HIV prevention information to sex workers on the street and public places may only work in certain situations because interactions with sex workers may be limited by the time availability of sex workers and their motivation to listen. Peers make the connection with the women initially by providing supplies such as socks, soap kits and providing information about different women only drop-ins in their neighbourhood, organized by different agencies partnering with HIPS. Peers mention that meeting the women over a couple of visits, helps in developing a rapport and building trust between them. Peers remark that this relationship building is crucial to engaging them on a long term basis. When peer workers were asked how they get street sex workers actively engaged in HIV risk reduction work. One of the peer workers observed,

> If you want sex workers to come to you, you've got to come to them first. You've got to meet them on their terms. You've got to walk where they've walked. You've got to be able to sit where they are sitting and offer them something. If you want them to move or go anywhere, you have to offer them something. It's how their

> world works. There's no altruism in their world; it's not I'll do you a favor for nothing. They're not geared to think that way anymore.

This observation may hold true while working with any community, but the peer's experience indicate that in order to engage street women who have been stigmatized and socially marginalized the peer has to start at a point where they are currently at. Sex workers are keenly aware of the stigma associated with sex work, many of the women mentioned that they feel judged by healthcare providers and staff in agencies providing services. Clients interviewed mentioned that peers speak their language.

Impact on Peer Workers

The HIPS project was developed as peer-led model primarily as a strategy to engage marginalized women. While selecting the candidates to work as peers care was taken to ensure that the selected women could effectively manage their own affairs and be able to organize themselves to work in a structured, fast paced setting. All the peers were employed on a part time basis for 6 hours per week. The part time work made it more difficult because they had to be quite focused in their efforts to be able to be able to meet the project objectives. Peers had to meet the demands of the work routines such as, outreach work, co-facilitating the drop-ins, providing HIV prevention workshops, meet the demands from women, distributing drug use kits and multi-tasking at times. These tasks tested their abilities in some aspects, especially if they had not worked in an office setting for some time. A peer worker while discussing her experience working on the project mentioned that she is able to handle the longer hours at work and thereby is not bored and getting into trouble unlike before. Peers indicated their experience of stability in their lives as a result of their involvement in the project. A worker commented,

> Personally, when I started in the HIPS program I had only just been recently housed and my life was not as yet stable. Over the past ….doing the work that I'm doing I have grown into a stability I've never had in my entire life. I mean literally because I had been a sex trade worker my whole life. I haven't had to get out there and turn a trick.

Peers report that the HIV education and the training has given them a sense of purpose. When asked about some of the rewards of their role, the peers indicated that the greatest reward for them was being able to make a difference in the lives of the clients. One peer indicated,

> When I go out there every day with the people I used to share space with when I was using more heavily. I could see that they're still alive. I could see them every

> day. My mind gets put at ease and it's like ….when I walk down the street and I see my friend…. 'oh God I heard you were dead' and it's like oh no I'm still alive. …I can stop worrying..…. I like the fact that I've made it out of that space. I've then turned around and I'm trying to give someone the person who's left behind a hand up, up to where I am.

Another peer mentioned that they see members of the target population as their "family" and their "sisters" and so they felt responsible to provide support to them whenever necessary, regardless of whether that support fell within the scope of their job. It must be noted however, that none of the peers expressed negative feelings towards providing additional support to clients even if it fell outside of their defined job description. Peers also felt positive about their work experience and that they were able to give back something to their community, and the experiences gathered over the years has provided them with the knowledge and skills and also prepared them for their work with the population. When peers were asked how their lives have changed since becoming a peer worker, one peer explained that her life was already beginning to change as a result of her participation in the first project and her self-esteem has increased. She explained,

> Just feeling validated and really being okay with my experience and not feeling you know… being able to release some of the oppression around it and the stigmas and really try and be a part of other peoples' journeys, even if that's just sitting and having a coffee with them. It really helped me look at myself and things and my own feelings around different things that I have gone through that society puts on you that I don't need to have. I've been able to let them go and throw them away and put them where they belong.

The comments reveal that peer workers are able to reflect and question the oppression and stigma associated with sex work. Peer work also helps the peers themselves in their own recovery process while helping others in similar circumstances. The peers in their efforts to motivate their clients to prevent their HIV risk practices also somehow feel obligated to model these practices in their own lives. The positive self- image they have of themselves on account of their involvement in peer work helps in this role modeling efforts of peers. A peer worker mentioned that since her involvement in the project she has been able to take care of herself and work on her health issues and address some personal challenges which she would have otherwise ignored. She mentioned " I would have just buried that, kept on going, maybe filled it up with a bit more dope, a bit more whatever. I just ignored it. But this program has given me this… well I've gotten an opportunity…." . The peers cited psychosocial benefits such as increased feelings of hope, a sense of purpose because they feel like they are making a difference, increased

confidence, validation and increased self-esteem since they started their involvement in peer work.

Peers are well aware that while doing outreach work they may meet with their friends with whom they may have used substances previously and this can be a trigger for them sometimes.
Peers usually do not go alone while doing outreach work for personal safety and also to keep themselves in check from such triggers. Since peer workers reside in the neighbourhood they frequently meet their clients. A peer worker comments about her clients,

> They know when I'm working and they know when I 'm not. So it has become…I'm the woman that they are looking at now and going 'where are you going and why are you always so busy. You always look good. You're always on the go. How did you do that?' Because they know I come from the street just from talking with me because I speak the same way they do.

Another peer mentioned that when her clients see her now doing well, it gives them hope that they don't have to be there forever, and they see that there is a way out and they have something positive to look forward to in their own lives. A peer mentioned that clients often ask her about her work and what she is doing, she mentions,

> I tell them (clients) what I'm up to and they go '…, how do I get involved in that.' I say 'you can become a peer worker' and they go 'well can I get involved in what you do.'..... I've met a lot of women out there who want to get involved in this, who want an exit strategy for them getting off the street. They want it but I am unsure of what to tell them, where to go.

Peers are perceived by their clients as role models, who have been able to get themselves a job, get their life together while playing an important role in the street sex workers community promoting self-care and increasing access to health care for the women.

One of the key issues mentioned by the peer workers and key informants is the lack of core funding for the HIPS program. It seriously impedes the expansion and sustainability of the peer program. In this regard one of the key informants remarked, "Funding is always a challenge for this kind of work. I mean we recognize it as being so vital but I find that it's the hardest thing to get funding for". The key informants claimed that the lack of core funding has a detrimental effect on the peer workers. In this regard a key Informant mentions "Project based funding is very frustrating because …we hire them for six months. You know they give it their all and then they know it's coming to an end and there's lots of anxiety". The key

informants and the peers expressed that given the temporary nature of peer work, peers often experience feelings of anxiety when the project is coming to a close.

5.8 Discussion

The purpose of this evaluation was to examine the effectiveness of a peer based model of outreach and support for HIV risk reduction and prevention among women and transgendered women engaged in sex work in downtown Toronto. The findings of the evaluation clearly illustrate that the HIPS peer led project was successful in increasing sex workers access to HIV education and harm reduction supplies. The focused outreach provided by peer workers to the spots frequented by street sex workers and women drug users has helped to connect with this key group of women. The vast majority of the clients mentioned that they accessed HIV education and harm reduction supplies from the peers.

The evaluation showed that clients find the drop-ins located in the different agencies in downtown neighbourhoods to be accessible. The drop-ins were also the most commonly used method of contacting the peer worker. The low barrier approach at the drop-in has particularly made the services accessible to more women. Furthermore the findings reveal that peer workers are able to use their experiential knowledge to engage sex workers and provide HIV education and solutions to the issues posed by the women. Implicit in this model is the peers modeling these behaviours in their lives. All this has helped them to improve their own confidence and knowledge about these issues.

The HIPS project was able to organize three additional voluntary POC HIV testing sites to serve the women identified by peers. Each site was consistently at capacity every month. It is important to note that the number of women that could get tested during POC clinics was determined by the capacity of Public Health clinics to complete the tests during the time that they were there. Most of the clients that participated in the study indicated that they heard about POC testing from a peer worker, whether during outreach or at a drop-in and that their interactions with peer workers directly influenced their decision to get tested for HIV. The findings also show that peer workers also provided a direct link for clients to both internal and external organizational programs.

According to Sarafian (2012), research has shown a positive relationship between social support, such as that received from a peer worker, and HIV/STI preventative behaviours such as HIV testing and condom use among women. In the study conducted by Sarafian (2012), social support was divided into six distinct categories, informational support, instrumental, appraisal, emotional, companionship and negative comments. In the case of HIPS peer workers, clients reported social support in all of the categories with the exception of negative comments. As part of their documented responsibilities, the peer workers provided a significant amount of informational and instrumental support to clients such as providing HIV education, information on safer sex practices, information about POC testing and referrals to other organizational programs and condom and harm

reduction supply distribution, however other types of support that were not defined responsibilities were also provided. For instance, accompaniment, which could arguably fall under emotional support and perhaps even form its own new category of support, was noted by over half of the respondents as a beneficial type of support that was provided by the peer workers. It is important to note that accompaniment was not a defined responsibility of the peer workers however, they often provided that service to clients who indicated that they needed it. As Sarafian (2012) states, "It could be suggested that this distinguishes peer educators from traditional health educators such as health professionals" (p. 672). Unlike traditional health professionals, the peer educators provided a broader spectrum of support to clients thereby fulfilling more of their needs and helping to build feelings of self-efficacy to enact behaviour change. This illustrates the vital role that peer workers played not only when it came to behaviour change surrounding HIV prevention, testing and safer sex practices among the target population of female sex workers, but also as it relates to improving access for this population to other health and services.

As is evident by the findings of the study, the roles and responsibilities of HIPS peer workers were extensive and varied. A large majority of these responsibilities fell within the scope of the defined job description however, as previously explained, there were many instances where peers performed duties that fell outside the scope of their job. Given the fact that peers had established connections within the community and within the target population, peers explained that clients often contacted them outside of working hours for assistance and support. This issue is important because the same connections that make peers highly effective in their roles may also present as a challenge for maintaining a healthy work-life balance.

The issue of boundaries is one of the key issues in the project. Peers workers are from the community and are currently living in the neighbourhoods in which they serve their clients. This poses some unique challenges to peer workers because clients may approach them at odd hours asking for harm reduction supplies or for supports. The role of the peer workers in such instances may not necessarily end at the stipulated office hours it may in fact extend into the evening hours. This may pose as a problem for the agencies employing peer workers who do not want them to work after their work hours. However the nature of sex work is such, wherein women are busy in the evening and late nights and are resting in the daylight hours. Their routines may not fit in with the regular office working hours to provide harm reduction supplies. Currently the gap in need for harm reduction supplies for sex workers and drug using women and the programming hours for most of the agencies providing harm reduction supplies is filled in by the peer workers. Agencies working with sex workers and the drug using women have to be aware of this issue, and evaluate service delivery schedules and develop creative solutions so that peers have some latitude in their work schedules.

Another challenge in peer work is the relationships which peers may have with their clients, which has both sides to it as an enabler and as a challenge. A peer may have a past history of a relationship with a client and thus the work of the peer maybe

complicated, this is also noted by some researchers; Faulkner and Basset, 2012, note that on account of a pre-existing relationship with an individual client, boundaries may become blurred between a peer and a client and there is a potential for emotional co-dependency. Mead, 2001 similarly points out that the issue of boundaries between peers and clients is complicated because the peer relationship is intended to be more akin to a friendship than a worker-client relationship. Peers thus have to navigate a fine line between their friends and clients. Additionally, a peer worker may have had an issue with a client in the past which may affect her/his work negatively, it is important to be able to work on such issues and help peer workers jointly develop solutions.

Peer workers meet many women in the course of their work some of whom are the most vulnerable and face violence on a regular basis from clients, predators, pimps and intimate partners. Such incidents may lead to vicarious trauma, or may bring back past experiences which may trigger re-traumatization of the peer worker. The organization engaging peer workers will have to be aware of such situations and make provision for the peer workers to communicate and debrief on a regular basis with their supervisor. Organizations will have to foster a relationship of trust and respect between the supervisor and the peers to help the peers feel comfortable to discuss these issues with their supervisors (O'Hagan, Cyr, McKee, Priest, 2010).

Organizing programs and engaging peer workers with lived experience to work with a specific population group such as street based women sex workers and women engaged in drug use requires agencies to review their policies and practices so that they are inclusive and non-discriminatory. Staff members in such organizations also need training to work with the peer workers and be aware of the program in order to be a welcoming place to work. Otherwise it can create tensions between rest of the staff and the peer workers and also their clients. In some instances peer workers are also clients accessing services in the same agency as their clients. The care provider staff–client relationship may not always easily transition to a care provider- peer relationship when a client takes up a peer position in the agency. Agency staff may thus not perceive peer workers as staff in the agency and peers may not be able to integrate themselves within the organization. On the other hand peer workers may not be able to transition and adjust working in a structured setting without adequate support and training. They may find the work too overwhelming and may require time orienting themselves into the work environment and schedule. This requires support from the agency engaging peer workers and agencies should also have policies and practices to be able to integrate peer workers well into the work place. This is an issue which has been explored in a previous report titled "Shifting Roles- Peer Work in Harm Reduction."

The HIPS project developed partnerships with several organizations to be able to connect to the women at the different drop-in programs and also to provide point of care HIV testing in different locations which may be accessible to the clients. All the partner agency staff should also have the required training to engage with peer workers and also have the policies in place to avoid discriminatory practices against peer workers. This can otherwise lead to several challenges in coordinating a project with peer workers.

Another theme that emerged in the findings is structural level barriers that impact on the expansion and sustainability of peer programs such as HIPS. A needs assessment conducted by UNAIDS (2012) revealed that a lack of financial resources presented a major challenge for the sustainability of many peer programs and the HIPS project is no exception. The findings also show that not only does funding limitations impact on the sustainability of the program but it also limits the amount of compensation that can be provided to peers and has a negative impact on the peers themselves. Key informants expressed that peer workers often experience feelings of anxiety when the project is coming to a close. This anxiety is not only related to the loss of income but can also be related to the loss of psychosocial benefits of their job. The HIPS peers all cited various psychosocial benefits such as an increased feeling of hope, a sense of purpose because they feel like they were making a difference in peoples' lives, increased confidence, validation and also increased self-esteem. In a study conducted by Guarino *et al* (2010), some peer workers cited that the structured activity provided by their role, their visibility in the community and the psychosocial benefits that they derived helped them to either reduce or control their own substance use and this benefit was also highlighted in the findings.

The lack of sustainability of the peer program can also potentially have a negative impact on the clients themselves because as the findings illustrate, the clients view peer workers not only as providers of social support, but also as a vital link to organizational programs and services and as a frontline point of contact. Both the peer workers and key informants explained that when dealing with the sex worker population, building trust between clients and the health care providers is often very difficult and so the peer workers help to bridge that gap and build their credibility within the community. According to Ditmore (2011) and as cited in the needs assessment that was conducted by Street Health and RPCHC (2014), female sex workers face a host of issues related to lack of empowerment, the dynamics of oppression, violence, stigma and discrimination and these issues have a direct impact on self-efficacy when it comes to behaviour change. The findings show that the connections and affiliations that peers form with clients help to build self-efficacy and so sustainability for peer programs is critical when it comes to helping clients in the decision–making process.

Sustainability of the program remains as an issue because of several factors, such as, lack of core funding for peer based programming; project based funding does not help to provide continuity of services. Peer workers will also be unable to sustain the partnerships and network of clients they have developed in the community if there is no long term vision and support for peer based HIV prevention. The HIV risky health practices and behaviours the peers have helped to prevent can only be entrenched in the sex worker and women drug using community if there is sustained contact with the marginalized women. Similarly the connections fostered by the peers between their clients and social support agencies and can only be strengthened with continued contact otherwise the work and advances they have achieved to date cannot be sustained.

6. 0 Conclusion

Despite the high prevalence of HIV among street based sex workers and women using drugs there is a serious lack of programmatic response, they thus remain an underserved group. The peer led model of intervention to prevent risk behaviours with education, skills building, provision of harm reduction supplies and social support enhancement adopted by HIPS to reach out to the women provides a successful model. This capacity building approach with peer workers has helped to make inroads into this otherwise inaccessible community. Healthcare providers and agencies working with sex workers and drug users should employ peers to reach out to the marginalized women to ensure that they have improved health outcomes for all.

7.0 Recommendations

Service Providing Agencies

i) Further research/evaluation studies should be done involving street sex workers and women using substances to assess the health impacts of peer sex workers and also to assess the benefits of peer models

ii) Peer based programming should be promoted as a method of reaching and engaging street based sex workers and women using substances for providing harm reduction and HIV prevention services.

iii) Health care providers and service providers should promote non-stigmatizing and inclusive policies, programs and practices which offer a welcoming environment for sex workers and women using substances.

iv) Increase access to safe spaces for street based sex workers, such as providing 24 hours drop-ins in accessible locations for sex workers and women using substances and late night safe space which can help women in crisis situations.

v) Voluntary HIV POC testing must be expanded and made available easily for people to know their HIV status and seek treatment earlier if necessary.

vi) Health care providers and agencies should develop programs and work with the sex workers and women using substances to ensure equity in health outcomes

Sex Workers

vii) Street sex workers should consider organizing themselves and also form coalitions/networks which will actively advocate and seek solutions and address issues affecting sex workers

All Stakeholders

viii) Addressing structural issues of chronic poverty, homelessness and unemployment can have a positive effect on sex workers and improve their access to health care and their health

ix) Violence against sex workers is a risk factor for HIV, solutions to prevent and address this violence should be developed in partnership with sex workers and /or sex worker led organizations and law enforcement

Sources Cited

Aceijas C, Stimson GV, Hickman M, Rhodes T. (2004). *Global Overview of Injecting Drug Use and HIV Infection among Injecting Drug Users*. AIDS. 18:2295–303.

Agarwal AK, Singh GB, Khundom KC, Singh ND, Singh T, Jana S. (1999). *The Prevalence of HIV in Female Sex Workers in Manipur, India, Journal of Communicable Diseases Mar 31 (1):23–8*

Alison Faulkner, Thurstine Basset, (2012) "*A helping hand: taking peer support into the 21st century", Mental Health and Social Inclusion*, Vol. 16 Issue: 1, pp.41 – 47 Emerald group Publishing available at http://www.emeraldinsight.com/doi/pdfplus/10.1108/20428301211205892

Bandura, A. (1998). *Health Promotion from the Perspective of Social Cognitive theory*.*Psychology and Health, 13,* 623-649.

Baral S, Beyrer C, Muessig K, Poteat T, Wirtz AL, Decker MR, Sherman SG, Kerrigan D.(2012*). Burden of HIV among female sex workers in low-income and middle-income countries: a systematic review and meta-analysi*s, Lancet Infect Dis. Jul;12 (7):538-49.

Basu, I., Jana, S., Rotheram-Borus, M.J., Swendeman, D., Lee, S., Newman, P., & Weiss, R. (2004). HIV *Prevention Among Sex Workers in India*. JAcquir Immune DeficSyndr. *36*(6), 845-852.

Catania, J.A., Kegeles, S.M. & Coates, T.J. (1990). *Towards an Understanding of Risk Behaviour: An AIDS Risk Reduction Model (ARRM).* Health Education Quarterly. *17*(1), 53-72.

Don C. Des Jarlais, Salaam Semaan, (2005) *Interventions to Reduce the Sexual Risk Behaviour of Injecting Drug Users, International Journal of Drug Policy* 16S (2005) S58–S66

Ditmore, M. H. (2013). *When Sex work and Drug Use Overlap. Considerations for Advocacy and Practice*. London, UK: Harm Reduction International.

Ditmore, M. (2011). *A Holistic Approach to HIV Prevention Programming for Female Sex Worker*s.*USAID.*

Guarino, H., Deren, S., Mino, M., Kang, S., & Sheldin, M.G. (2010). *Drug Users as Change Agents.Training Drug Treatment Patients to Conduct Peer-Based HIV Outreach: An Ethnographic Perspective on Peers' Experiences*. Substance Use & Misuse, 45, 414-436.

Grinstead O, Comfort M, McCartney K, Koester K, Neilands T. (2008) *Bringing it Home: Design and Implementation of an HIV/STD Intervention for Women Visiting Incarcerated Men*. AIDS Educ Prev. 2008 Aug; 20 (4):285-300.

Harris, G. E., & Larsen, D. (2007). *HIV Peer Counseling and the Development of Hope: Perspectives from Peer Counselors and Peer Counseling Recipient*s. AIDS, Patient Care and STDs, *21*(11), 843-859

Jana, S., Basu, I., Rotheram-Borus, M.J., & Newman, P.A. (2004). *The Sonagachi Project: A Sustainable Community Intervention Program.* AIDS Education and Prevention, 16(5), 405-414.

Joint United Nations Programme on HIV/AIDS [UNAIDS]. (1999). *Peer education and HIV/AIDS: Concepts uses and challenges.* Geneva, Switzerland.

Kral, A. H., Bluthenthal, R. N., Lorvick, J., Gee, L., Bacchetti, P., & Edlin, B. R. (2001). *Sexual Transmission of HIV-1 Among Injection Drug Users in San Francisco, USA: Risk-factor analysis*. Lancet, 357(9266), 1397–1401

Latkin, C.A., Hua, W. & Davey, M.A. (2004). *Factors associated with peer HIV prevention outreach in drug user communities*. AIDS Education and Prevention, 16(6), 499-508.

McKensie, J. F., Neiger, B. L., & Thackeray, R. (2009). *Planning, Implementing, & Evaluating Health Promotion Programs.* A Primer (5th ed.). San Francisco, CA: Pearson Education, Inc.

Mead, S., Hilton, D., & Curtis, L. (2001). *Peer Support: A Theoretical Perspective*. Psychiatric Rehabilitation Journal, 25(2), 134-141.

Maloney J., (2006) *The Challenge of Change: A Study of Canada's Criminal Prostitution Laws, Report of the Subcommittee on Solicitation Laws*. Available at http://www.parl.gc.ca/Content/HOC/committee/391/just/reports/rp2599932/justrp06/sslrrp06-e.pdf

Norr, K.F., Norr, J.L., McElmurry, B.J., Tlou, S., & Moeti, M.R. (2004). *Impact of Peer Group Education on HIV Prevention Among Women in Botswana*. *Health Care for Women International, 25,* 210-226.

O'Hagan M, Cyr Céline, McKee Hr and Priest R for the Mental Health Commission of Canada (2010). *Making the Case for Peer Suppor*t: Report to the Peer Support Project Committee of the Mental Health Commission of Canada

Ontario Women's Justice Network. (2014). *Sex work and the Law: A Changing Legal Landscape* available at http://www.cleonet.ca/instance.php?instance_id=4286

Public Health Agency of Canada (2012), *At a Glance- HIV and Aids in Canada Surveillance Report*
Available at http://www.phac-aspc.gc.ca/aids-sida/publication/survreport/2012/dec/index-eng.php

Region of Waterloo Public Health. (2004). *Peer Program Evaluation: Capacity Building through Peer Programming.* Waterloo, Canada.

Roberts A, Mathers B, Degenhardt L, (2010) *Women who inject drugs: A review of their risks, experiences and needs* (Independent Reference Group to the United Nations on HIV and Injecting Drug Use, 2010). Available at www.unodc.org/documents/hiv-aids/Women_who_inject_drugs.pd

Sarafian, I. (2012). *Process assessment of a peer education programme for HIV prevention among sex workers in Dhaka, Bangladesh*: A social support framework. *Social Science & Medicine, 17,* 668-675.

Shiner, M. (1999).*Defining peer education*. Journal of Adolescence, 22, 555-566.

Spittal, P.M., Bruneau, J., Craib, K.J.P., Miller, C., Lamothe, F., Weber, A.E. et al. (2003).*Surviving the Sex trade: A Comparison of HIV Risk Behaviours among Street-involved Women in two Canadian Cities Who Inject Drugs.* AIDS Care, 15(2), 187-195.

Street Health & Regent Park Community Health Centre [RPCHC]. (2014). *Street Based Sex Workers Needs Assessment.* Toronto, Canada.

Penn R, Mukkath S., Henschell C., Andrews J, Danis C., Thorpe M., Thompson M., Gao Y., Miller C., and Strike C. (2011) *Shifting Roles: Peer Harm Reduction Work at Regent Park Community Health Centre*: Centre for Addiction and Mental Health

Toronto Community Health Profiles Partnership. (2011). Regent Park Profile: Leading causes of premature mortality. Retrieved from: http://www.torontohealthprofiles.ca/a_documents/

United Nations Office on Drugs and Crime. (2014). *Policy Brief – Women Who Inject Drugs and HIV: Addressing specific needs*. Vienna, Austria.

United Nations Office on Drugs and Crime, *World Drug Report 2014* (United Nations publication, Sales No. E.14.XI.7). Available at http://www.unodc.org/documents/wdr2014/World_Drug_Report_2014_web.pdf

Appendix A

Outreach and Education Stats October 2013 -June 2014 (RPCHC, Sherbourne, All Saints)

	# of women Reached	# of women who received HIV Education	Internal Referrals	External Referrals
September	**41**	**34**	**22**	**12**
October	**308**	**126**	**64**	**56**
November	**216**	**81**	**78**	**60**
December	**156**	**75**	**46**	**65**
January	**140**	**96**	**35**	**40**
February	**150**	**65**	**60**	**57**
March	**127**	**37**	**51**	**46**
April	**116**	**50**	**41**	**36**
May	**84**	**39**	**56**	**38**
June	**94**	**25**	**28**	**19**

The Month of Sep 2013 peers were engaged partly in training. The low figures for the month of May and June was on account of two peers being assigned to other project activities.

Appendix. B

Profile of Survey Respondents

Chart.1

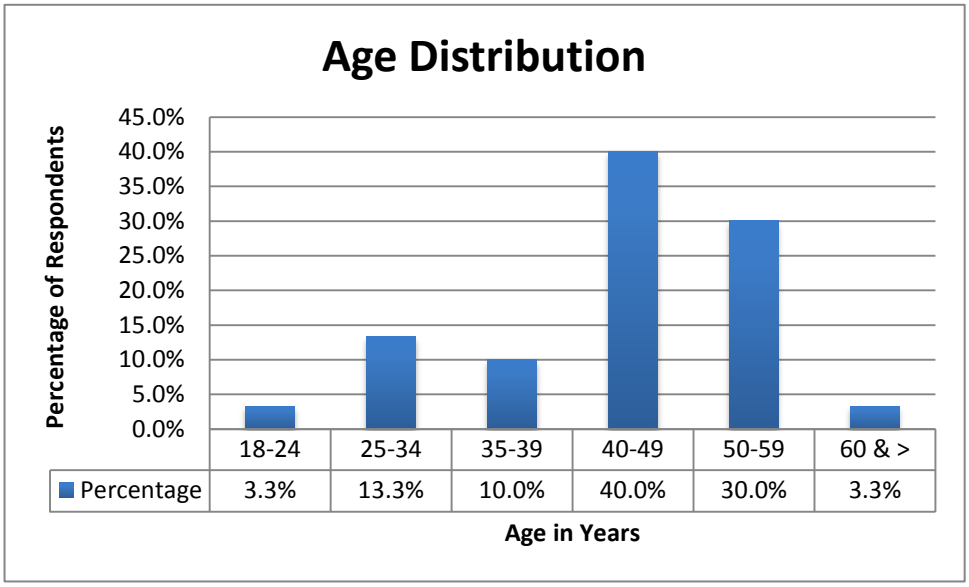


Chart .1 Distribution of survey respondents by age (n=30)

Chart.2

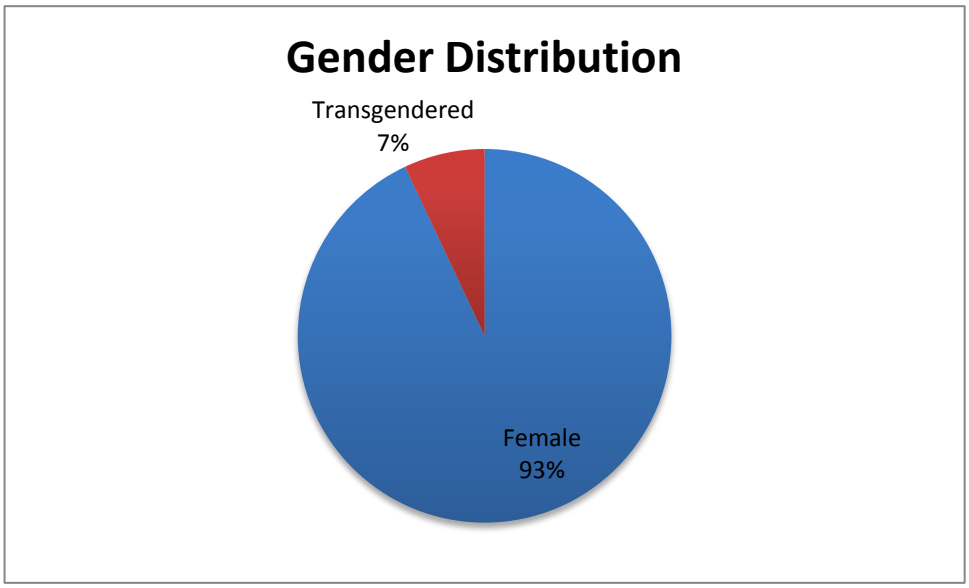


Chart. 2 Distribution of survey respondents by gender (n=30)

Chart.3

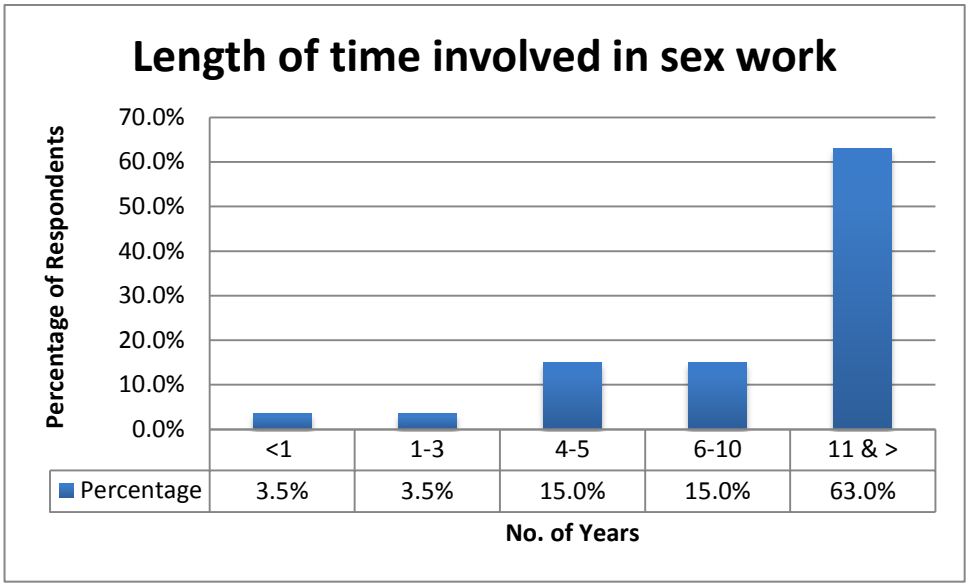


*Chart 3.*Distribution of survey respondents according to number of years involved in sex work (n=30)

Regent Park Community Health Centre