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WINNIPEG REGIONAL HEALTH AUTHORITY,
POPULATION AND PUBLIC HEALTH HEALTHY SEXUALITY
AND HARM REDUCTION

STREET CONNECTIONS/OUTREACH SERVICES EVALUATION REPORT 2016

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Introduction and Background

In operation by the WRHA's Healthy Sexuality and Harm Reduction team (HSHR) since 2001, *Street Connections (SC)* is a WRHA public health program. Street Connections' ultimate goal is to reduce the spread of sexually transmitted and blood-borne infections (STBBIs), and to reduce other drug-related harms in Winnipeg.

SC works primarily with individuals who use illegal drugs, individuals involved in the sex trade, men who have sex with casual and anonymous male partners, and street-involved persons. The main way to reach these populations is via a mobile service. Circulating six nights a week from about 6pm to midnight, harm reduction supplies, information and referral, and nursing services (e.g., testing, immunization, etc.) are provided throughout well-established routes. These services are provided at the office of the HSHR's office during the day-time, Monday to Friday.

In 2013-2014, the HSHR conducted a thorough evaluation of SC[1] and the outreach services to better understand the operation of the program, including the extent to which the current times, locations and services responded to clients' needs, and to observe how the promotion of Safer Crack Use Kits/safer inhalation units promoted health among their users. A main conclusion of the evaluation was that within the current configuration of services, *nursing services were periodic and underutilized*. It was found that this was mostly in the evening mobile services. Along that conclusion came a number of recommendations which point out to a need for "reimagining" the operations of the program.

The reimagining of the operations of SC meant that both Outreach Workers and Public Health Nurses fulfill their scope of practice while addressing the recommendations of the evaluation. The recommendations indicate that with these changes there comes a promise that the program will not only continue to more efficiently and effectively serve those in need of the services, but maximize the accessibility of these services by more strategically engaging partners across the health and social sectors, and potentially beyond. Acting upon these recommendations meant that adjustments to the roles of both, nurses and outreach workers (always within their competencies) were required.

As recommendations were put into action, and while the program re-oriented itself, the main goal of this phase was to enhance the operations of Street Connections by optimizing the team competencies.

It was believed that once the new activities have gained track or have been revamped to better fulfill the ultimate goal of the program, the program should be ready to review the evaluation framework for carrying out the evaluation of its outcomes.

Evaluation Scope and Purpose

[1] Ross, C. (2015). *Street Connections/Outreach Services Program Monitoring and Evaluation Report For the year October 1, 2013 to September 30, 2014*, retrieved from http://www.wrha.mb.ca/extranet/publichealth/files/services/healthy-sexuality/SCEval2015.pdf

While SC's goals and core activities remain the same, the ways in which they are delivered have been changed. As plans are created and recreated, and the HSHR team finds its way, the evaluation model required to capture the influx of activities also requires a certain degree of flexibility. For this, we propose an adaptation of a model that straddles both, *developmental evaluation*[2], and *process evaluation*[3]. This is so, as the program is already established, but is changing its ways of delivering the activities.

For the purpose of the evaluation of this transitional phase, a few key questions will guide the process. These questions are:

Overall question:

- How does the implementation of a reimagined SC look like?

Secondary empirical questions:

- How are/have the changes/recommendations been implemented?
- Have the changes affected Street Connections/Outreach's services? In which ways?
- What have been some of the challenges? And some of the opportunities?

This evaluation has been successful due to the ongoing input from many members of the HSHR team.

In this report we reflect upon the changes in operation and what they mean in support of the mandate of the Healthy Sexuality and Harm Reduction from the perspectives of the management and staff involved in this process throughout the time of evaluation.

Methods

This evaluation focused on the processes that were put into motion to ensure the full scope of practice of the SC personnel. For Public Health Nurses, this required aligning SC duties with the recently-implemented WRHA *Public Health Nurse Professional Practice Model*.[4] A formalized model does not exist for outreach workers, and so evolving that position was more organic. As such our main interlocutors in the research are those involved in delivering SC services.

The methods used to answer our evaluation questions were:

Qualitative interviews. Members of the HSHR team involved with SC were interviewed at two points throughout the length of evaluation. The first interview occurred soon after the major

[2] Developmental evaluation is an evaluation approach that can assist in context of innovation and adaptation in dynamic environments. See, Patton, M. (2006). *Developmental Evaluation*: *Applying Complexity Concepts to Enhance Innovation and Use*. New York, NY: Guilford Press.

[3] Process or formative evaluations help a program become an effective and dependable mode. See Mathison, S. (2005).*Encyclopedia of Evaluation*. Thousand Oaks: Sage Publications.

[4] Cusack, C. (2014). *Public Health Nurse Professional Practice Model*. Winnipeg: Winnipeg Regional Health Authority. Retrieved from http://www.wrha.mb.ca/extranet/publichealth/files/PHNPPMPSversion2014Sept5FINAL.pdf.

changes started to take effect (i.e., reduction of nursing staffing in evening mobile services). The second series of group interviews took place towards the end of the evaluation process. An interview was conducted mostly with nurses, another interview with outreach workers, and a third one, with managers. The interviews followed an unstructured approach having as a guide the evaluation questions, and the initial work plan developed by the team.

Documentation review. Documents such as notes of planning meetings, of meetings with team members, evaluation, and so forth, were reviewed to enhance our understanding of processes in place in the deployment of program, and to further contextualize this evaluation. A couple of evaluative questions were asked at the initial planning and staff meetings to secure data on emerging issues. As changes become routinized, and new issues that required immediate attention were able to be handled on the spot, regular intensive meetings turned into 15 to 20 minutes check-ins with no written records.

Ethical Considerations

That, to a large extent, we wanted to understand the experiences and perspectives of members of the HSHR team involved in Street Connections and Outreach services, raised important ethical considerations. We understood that as members of the team have participated in the evaluation of the program, understood the changes, and supported the planning process, it was in their best interest to participate in the evaluation. However, it was important to clarify any ethical implication of their participation. This was particularly important as the team is small, and having to position each individual on their main roles may give away the identity of the participant.

Special attention was paid to ensure that findings do not reveal the identity of our interlocutors. However, we were also aware that in some cases there was a need to include references to the roles (e.g., nurse, outreach personnel, manager, etc.), which may lead to disclosure.

FINDINGS

Laying the Groundwork for Change

As suggested, the success of the re-orientation of the program hinged largely on the redefinition of on-the-ground roles for both the Public Health Nurses (PHNs) and the Outreach Workers (OWs). Without compromising the integrity of each of these positions, the plan was to enhance the potential outcomes by better integrating each other's responsibilities.

During the initial planning and evaluation processes it became evident that much discussion occurred around the competencies and scope of work of both the PHNs and the OWs. The new plan required that SC/OW activities be reassessed while keeping in mind staff's work routines, what each other understood their job was, and of course, job descriptions.

A collective planning process was conducted to tackle the recommendations of the 2013-2014 evaluation, and address the roles OWs and PHNs would perform in moving forward. This process required that everyone re-familiarized him/herself with the recommendations, and fully participated in the decision-making process. The list of recommendations were summarized at a meeting, where staff voted on what they believed to be the priorities. Staff discussed their selections based on their experiences, how their choices may contribute to positive changes, and would be achievable throughout the year ahead. The following were the priority items resulting from those initial discussions:

- Broadening partnerships for increased supplies distribution accessibility beyond SC
- Developing a strategy to facilitate linkages to care of people living with HIV and HCV
- Incorporating the findings from a mapping project[5] intended to improve the understanding of individuals who may be underserved by current SC's services
- Reassessing the current education materials

Discussions also covered a number of areas which were, at the time, deemed of lesser priority, and issues that required ongoing attention. As SC/OWs operations and focus shifted since the implementation of the changes, some of these items may be deemed non-relevant (e.g., "increase presence on community tables/meetings and increase presentation") and others may become more of a priority (e.g., "Naloxone implementation").

By developing the plan in collaboration and being able to observe and understand who was to do what, and how these complement each other's work, it made for a more cohesive understanding of the overall work of SC and Outreach services. [6]

[5] The Healthy Sexuality Harm Reduction team has been involved in a mapping project (i.e. of locations frequented by Street Connections' priority populations) in collaboration with the Centre for Global Public Health (University of Manitoba) and Sunshine House.

[6] It is important to indicate that not everyone attended these meetings, and that new staff was incorporated later on.

The revamping of SC operations called for a reduction of PHNs time in the evening mobile unit; and an increased presence of OWs in evening supplies distribution. That PHNs be more readily and available to work during the day, and OWs more involved during evening mobile services required changes in some of the work routines. During the meetings and the more focused sessions designed for evaluation purposes, much of the conversation revolved around "making" it work for everyone. This is perhaps more salient when it comes to providing services out of conventional office hours. While the PHNs would benefit from a reduced evening schedule, the OWs would have to re-adjust not only their schedule (and recalibrate their lives outside work), but also their new work configuration (i.e., non-reliance on nurses).

Still, during the evaluation process some staff indicated that not everyone was fully informed of decision-making processes. This may be in part due to the need for ongoing adjustments that changes in operation required on a timely basis, and as some would indicate, to the limited communication strategies put in place. For instance, some staff had questions about what the work looks like now that personnel shift has occurred, suggesting that some may not be as familiar with some of the new set of activities people are working on.

Along with the initial discussions it came a need to ensure that clients were not hugely affected from changes in services. With the view that OWs will take a more prominent role in the van – as some nursing services were not in high demand on a daily basis through this service – in-house knowledge transfer of some care and support for clients that have been largely dealt by nursing personnel was conducted. Training was conducted to create some consistency and smooth response to mostly intravenous injection drug users, as this sector of the clientele tends to present with some specific health concerns. Vein care along with an assessment of risks related to drug use, use and access to harm reduction supplies became key topics. It appeared that this training was well received and useful for the OWs. On the other hand, there was a question about transfer of nursing responsibilities to OWs.

Further, when asked about what OW observed now that nursing services were not available in the van on a daily basis, the OW felt that they had not seen any particular request for nursing services when only OW provide services.

In a nutshell…

- Team planning to address evaluation recommendations helped in acceptance of process of change;
- Knowledge transfer (in particular around some common functions nurses took charge of) assisted OWs in their evening shifts;
- Monitoring of work helped to address some newly identified issues on a timely basis;
- Communication of changes and the current activities conducted to reach out the SC population of interest remains of a concern to some.

Partnerships for Harm Reduction

In view of the current increases in demand for harm reduction supplies, and a need to increase their accessibility where people live or meet, PHNs took on the lead of broadening distribution partnerships. This included the identification of potential sites or responding to requests for services – some of which were based on the mapping project. Since the implementation of the new work plan, partnerships with non-profit and private sectors had been established or were in discussion.

Harm reduction supplies distribution points have been expanded to include some private business (i.e., pharmacies) in the North End and West Broadway areas. These sites have been identified as they are or have been locations where the main population of interest access other drug related services. A major plus with some of these new sites it is that provision of supplies through these businesses also expand accessibility all week-long. A community health centre (Klinic) has also agreed to provide supplies to anyone requiring so on Saturdays through their Saturday's STI testing clinics.

Staff indicated that a major challenge was how far to go in establishing new community/business partners within the budget currently available for supplies. This discussion occurred around increased demand, and in view of a need for a thoughtful plan for distribution that truly reaches the populations of interest. However, it still too early to fully assess how these new distribution points were working, including what it means for HSHR services to distribute supplies through third parties (i.e., less engaged contact with individuals seeking these services).

The geographic mapping study to determine locations where people engage in "high-risk" activities throughout Winnipeg helped to determine supplies distribution points. For instance, one of the locations identified was in the West End neighborhood. At the time of the evaluation conversations were initiated with a youth focused organization rightly located. However, for an organization without experience with health issues around drug use, the introduction of needle distribution may not be an easy decision to make, it was anticipated.

On the other hand, another community organization in the West End area has approached SC to have services at a drop-in space being created for people involved in the sex trade.

To increase access to harm reduction supplies through WRHA's primary care services throughout the city, HSHR/SC staff initiated this process by presenting to the Population and Public Health Operation Team. Firsthand experience of working with clients requesting supplies, what this means in terms of staff competencies, establishment of facilities that accommodate these services, and other programmatic and policy issues would greatly assist in infusing and diffusing harm reduction principles and practices throughout the WRHA services.

Access to supplies through WRHA primary care facilities has the potential to help with the ongoing dilemma of engaging people seeking supplies to primary care, including STI/BBI testing.

Many of those accessing both harm reduction supplies and nursing services (e.g., testing, vein care) from SC are not engaged in conventional primary care, and as such they tend to consult on additional health concerns. Staff believed that this move agreed with the WRHA's position on health equity.

Additional distribution points were deemed responsive to the needs of clients. However, they may also expand access to new services or networks of care. For instance, those seeking supplies in pharmacies may engage in health-related conversations with staff. What the outcomes may be will require further investigation.

The partnership development work illustrated in this section demonstrates that the expansion of these services requires time and that each site may require different type of support to "get there." It is also noteworthy, that not everyone in the team was aware of the efforts to expand services through this means, and above all to justify that these services will rightfully reach the "traditional" SC clientele.

In a nutshell…

- Supplies distribution has been expanded through diverse partnerships (i.e., businesses, and not-for-profit organizations);
- Partnership development for supplies distribution requires careful consideration, and takes time.
- New supplies distribution partnerships implies increased accessibility to supplies in places where people live or meet.
- This also implies an opportunity to learn about supplies distribution through diverse users' networks.
- Budgets may constrain the extent to which new partnerships can be established.
- Increased number of supplies distribution sites also requires staff time allocation to restock these new sites.

Testing Clinics: Making Testing Work for Mobile Services

Testing clinics are a strategy to dealing with the shortcomings of providing STI/BBI testing services out of a mobile unit (as testing requires time), and making testing accessible to communities, which are more likely to engage with services where they are at. These clinics are done in partnership with neighborhood embedded community agencies.

Stationary temporary clinics for part of the evening shifts were established at different locations (i.e., community organizations) where to reach the population of interest. For

instance, a Saturday testing clinic was set up in partnership with the Ndinawe Youth Resource Centre, in the North End of Winnipeg. Another testing site was established at River Point Centre (which provides addiction services) in the downtown area.

Increased available of testing services in places where people who are not usually engaged in primary care or may be at vulnerable for contracting STIs or BBIs was believed to optimize SC testing services. PHNs assessed that now that their services had been reduced to two nights a week, and that they are for part of the time stationary prompted them to offer testing more overtly. They explained that now, whenever clients approach them, among the array of services they provide they emphasize testing. An account of the number of tests provided since the changes in the operations indicated that there was no major reduction in number of tests performed when compared with the period previous to the changes. On the other hand, a question was raised about the extent to which the population reached in these locations matched the original population SC was set up to reach out.

Staff reflected on some of the sites where testing has been offered, including two local bathhouses, and a local university. Testing services at these bathhouses continue to be provided at each site one Friday per month. Scheduling male personnel for these services and personnel who is comfortable in providing services in these locations presented some challenges. Further, PHNs indicated that although much of the impetus for working in the bathhouses was to address syphilis outbreaks, no positive tests have resulted from their testing. They believed that this was not necessarily because syphilis was not circulating among the patrons, but more to the patrons' hesitation to have a record that indicated they had been tested. In the absence of anonymous syphilis testing, these men are reluctant to test, PHNs assessed. As such the PHNs wondered if there was a need to reassess their presence in the bathhouses.

As per the testing clinic at the university location, staff was not providing testing any longer at this site. The decision was based on the assessment that full primary care were available in the premises. Staff understood that their services were welcome and acceptable as students seemed not to seek STI testing from primary care at the university. On the other hand, while performing STI/BBI testing, the HSHR team demonstrated a great need for these services as they were able to find positive tests on a regular basis.

It was believed that in places where other health care services were provided, this was only a temporary option till the current services were able to do so. PHNs indicated that there was a need to assess their role in helping health practitioners at these sites to perform STI/BBIs counselling and testing.

Street Connections Direct Supplies Distribution

Direct supplies distribution is the main focus of SC work. With the changes in the operations of both the evening and day services, we assessed how the work with clients looked like in the office and the van from the staff perspective. It is important to note that there has been an increased demand on harm reduction supplies, specifically needles/syringes (WRHA HSHR 2016).[7]

As part of the evening services routine there is a number of scheduled stops where people can access the services, as well as distribution to some private locations (i.e., home visits). Home visits are scheduled ahead of time to try to fit them in within the schedule. It is not uncommon that some request cannot be fulfilled, and as such the purpose of increasing access to harm reduction supplies through other locations (as above referred) may help in bridging this gap. Yet, with no need to load nursing supplies on a daily basis, it was mentioned, the OWs could be on the streets earlier and accommodate additional distribution points.

As nursing personnel would not be available on a daily basis in the evening, we asked the staff about clients' reactions to this change. In our first focus group with staff, OWs made reference to clients' asking about a particular nurse or nursing services. However, later on, it appeared that many regular clients did not continue to ask, suggesting that they now know of when nurses are available and/or that they know that there is no nursing services on a daily basis. Some OWs felt that it would take a long time for some of the clients to realize the change. Without an in-depth analysis which includes the perspectives of clients, it is difficult to fully assess the daily evening withdrawal of nursing services.

OWs are now aware of how to address vein or wound care questions. Still, staff mentioned that referrals for appropriate vein care remained a challenge. As an illustration of successful referrals, one of the nurses indicated that in the last few months she had successfully referred a number of clients to a centrally located community health centre.

Direct supplies distribution also occurs at the Street Connections office. Staff mentioned that they had observed an increase in walk-ins. For this, trained staff were fulfilling these individuals' requests. This in turn has caused disruption of other work, in particular when the main need has been access to supplies. To deal with this dilemma, administrative staff are now offering supplies to clients. Further, changes in staff schedules and responsibilities has also helped in the interaction with clients resulting in more flexible work to respond to clients' needs.

However, some discussion occurred around the ways in which calls to staff for daytime services were triaged. OWs had been asked to receive all the calls, and refer those requesting nursing services to nurses. Some believed that when those request were easily identified by the front

[7] WRHA Healthy Sexuality and Harm Reduction (HSHR) Program Monitoring Report: January 1 – December 31, 2015 http://www.wrha.mb.ca/extranet/publichealth/files/services/healthy-sexuality/HSHRMonitoring2015.pdf

desk personnel, they should be directed to the nurses. Staff believed that these additional calls distracted them from their own work, including taking calls from the SC phone line. That now there are two numbers, one for nursing services and the SC line presented some issues. OWs felt that a number of calls for supplies distribution were missed because of the way phones and calls are managed.

To take a quick pulse of the acceptability of changes in the delivery of supplies at Street Connections office, a quick, short survey was administered with clients for a short period of time soon after the implementation of the new work plan. Most respondents were positive to having access to supplies and the nursing services. Most importantly, the survey revealed that while respondents indicated that the best option for them was to interact with trained staff (i.e., nurses and outreach workers), for over half of them it would be "best" or "okay" to receive the supplies at the front desk from the administrative staff. This suggests that the option to get supplies is quite acceptable, and that clients do not need to see trained staff at all times. Results from this survey indicated that clients helping themselves to supplies was the less desirable option for them.

However administrative support are handing out supplies, there is still an ongoing need for services from PHNs and OWs. Nurses indicated that there appeared to have been an increase in walk-ins at the SC office. Clients not only come for supplies, but also for testing. It was believed that many clients preferred this service because of convenience (e.g., no wait list, potential quick access to treatment, etc.). Some work has been done to identify frequent users of this service to work on proper referrals to primary care services in the community. This work was ongoing.

Changes in plan affected the availability of Outreach staff to do work in the community during the day. This resulted in having to find ways in which they were able to do meaningful work in the office. Nurses found that having an OW in the office was of great help to the apparent increased walk-ins, and the disruptions to calls with clients. In view of this reality, a nurse wondered about the apparent mismatch between what it is usually thought about outreach and what the actual work has turned out to be (client support). On the other hand, historically OWs have focused more on one-on-one work with clients than other activities. Taking this into account, some of the OWs were trying to think of way of reinventing their role, including through online outreach.

Staff fill out a forms (i.e., stats forms) to keep track of supplies distributed and other services provided. An electronic system for more timely and accurate recording had been developed, but not implemented. It seemed that recording of services through this form continue as before.

In a nutshell…

- There has been an increased in harm reduction supplies during daytime at the SC office.
- Clients requesting services from SC office prefer to interact with staff, presenting an opportunity for meaningful engagement and assessment of further needs.
- The ways in which clients' requests for nursing services during daytime (i.e., management of phone) appears to be an unresolved issue between OWs and PHNs.
- The reduction of OWs during the daytime has reduced their time in the community (outreach outside the office), leading to reconfigure what outreach from the office looks like, and wonder if/what impacts this has.
- From the perspectives of staff, it appeared that the changes in nursing availability in the van are slowly to become acceptable.

Harm Reduction through Community Education

The HSHR team is invited to do presentations on STI/BBIs and harm reduction to groups at different locations, including university, residential facilities, youth centres, etc. Part of the plan was to revise the current content of the presentations. However, within the context of what the work turned out to be, this plan has been adjusted to assess the overall worth of providing community education. With an increased need for direct services to clients, and an understanding that there are many community organizations that do already similar education sessions, an assessment of what specific education work the HSHR staff should be delivering was underway at the time this evaluation had concluded.

In a nutshell…

- Originally, the team had identified to revamp the content of community education presentations;
- As result of shifts in work schedules, capacity, and newfound needs, this plan has been expanded to reassess the overall provision of education sessions in the community;
- By the time of this evaluation, this assessment, which included a consideration for what other education services were available in Winnipeg, had not been completed.

Conclusions

In weighing the original plan of the implementation of changes to the operation of the SC and outreach work based on the recommendations of the 2013-2014 evaluation, it becomes evident that much has been accomplished in the past year. The reconfiguration of the program's operation seems to have resulted in a more effective and efficient use of personnel. Evening nursing personnel had been allocated to two days, while outreach workers' evening work increased. Now, nursing personnel has been able to develop strategies to tackle some of the recommendations set in the last program evaluation, as well as tackling new initiatives—for example, the take-home naloxone program—that have successfully included and engaged both nurses and outreach workers.

Partnerships for supplies distribution had been expanded in the direction suggested in the evaluation. With increased demand for supplies, this expansion is more than desirable. Daytime access to supplies at the office is desirable for many. Clients requesting supplies at the office prefer to interact with staff, suggesting that access to supplies may be more than just to these tools, but access to a service that may connect them with other services they need.

Evening testing clinics in locations where people in need meet or receive other relevant services have also proven to be an appropriate strategy. This account for the dilemmas of testing in mobile services, without undermining the portability and mobility of these services.

The changes have also led to rethinking the role of the HSHR staff in community education. When weighed against the available sexuality, sexual health, and harm reduction education currently available in Winnipeg, the limited education sessions that the HSHR staff are able to provide needs reassessment.

Still, as this is an ongoing work and communication on specific changes, and above all decision-making processes may not have reached everyone in the team as some staff raised a number of questions about the need for a full assessment of the impact of these changes.

Recommendations

The following recommendations are not laid out in any particular order. Some of these concern the work of OWs or PHNs; however, in most cases to operationalize these it would require teamwork (e.g., knowledge transfer, team planning, working in tandem, etc.).

As much of the work was work in progress, including the development of new partnerships for supplies distribution, re-assessment of education materials and the future of community education, improved client support for those requesting supplies during daytime, it follows that solutions to dilemmas around these issues will become apparent as more information on these matter become clearer. However, the following are some recommendations that stem from what transpired from what the HSHR team shared during this evaluation, which could move forward the established work to date.

Considering the different experiences and views in personnel in relation to the implementations of changes to the operation of Street Connections and Outreach Services, it may be appropriate to

- **Develop a communication strategy that reaches out to everyone on the knowledge to date of the outcomes of the changes, including the specific work that both OWs and PHNs are currently engaged in, and the challenges the changes present to them.**

With a desire by clients to see trained personnel, Naloxone becoming available, increased capacity of OWs to deal with more complex demands by clients (e.g., vein care), and availability of OWs during daytime to engage with individual clients, it may be appropriate to

- **Conduct additional training or orientation with OWs on assessing needs of clients, including assessing their access to supplies in SC office.**

Now that OWs are in a position to remain in the office during the daytime, there may be an opportunity for them to tackle another matter raised during the initial planning process, that is, online outreach. In this vein, it is suggested to

- **Develop a plan for online outreach by assessing the state of the art in this field, in terms of current social media platforms known to be of current popularity in Winnipeg, and any best ways of approaching those "hooking up" online.**

Considering that now HSHR personnel are also restocking supplies at distribution points in the city, it is may be appropriate to

- **Plan and design ways to assess these distribution points during this activity by engaging with those running the businesses or agencies, or clients at those locations.**

Supplies distribution through partnerships helps in normalizing harm reduction services within and outside public health services. With expansion in distribution points and increased demands for supplies come budgetary concerns, but also the opportunity for clients to engage with services where they live,

- **Follow-up with WRHA's potential venues where, according to the mapping inquiry, and bulk of home visits, clients should be able to access not only supplies, but primary care services.**

For current temporary evening testing locations with health professionals, and the capability of providing STI/BBIs testing,

- **Assess health care personnel's (i.e., nurses) needs with regards to the provision of STI/BBI counselling and testing (e.g., behavioural risk assessments, referrals, type of tests available, etc.) in order to offer training and assistance in making their services responsive to the populations they serve.**

With regards to the SC mobile services, to ensure that the changes have not affected the access to services to this population who seek evening services, it remains important to

- **To assess through an understanding of current data collected by staff, and direct engagement with clients (as done for clients requesting services in the office) the implications of the changes in operations (i.e., reduction of nursing services and the impact of distribution supplies when nurses are available)**.