Evaluation of *Harsh Reality*:

A Sexual Health Resource for Winnipeg Street-Involved Youth

by

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Abstract

Harsh Reality is a print resource aimed toward the population of street-involved youth. Created by a working group of street-involved youth in partnership with a research nurse, *Harsh Reality* is a unique hybrid of factual information, and art and written experiences submitted by street-involved youth themselves. *Harsh Reality* contains information about a variety of topics, notably sexually transmitted infections and HIV.

A case study method was used to evaluate aspects of both project process and outcomes. The case study was guided by three areas of study: street-involved youth's perceptions of the resource; retention of specific knowledge outcomes from the resource, and method of resource distribution. The primary sources of data were street-involved youth themselves. Findings of this study include a description of the target audience's perception of the resource, an analysis of specific knowledge uptake, an assessment of various methods of resource distribution, and possible suggestions for future resources.

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Dedicated to my parents,

Jackie & Dennis Snarr,

Without whom nothing would be possible, not even the dream to try.

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List of Acronyms

ABC's of Prevention – Abstain from sex, Be faithful, Condom use

AIDS – Acquired Immune Deficiency Syndrome

ASL – Average Sentence Length

ASW – Average number of Syllables per Word

CAUSE Canada – Christian Aid for Under-Assisted Societies Everywhere (NGO)

CIHR – Canadian Institutes of Health Research

CRC – Community Resource Centre

FKRS - Flesch-Kincaid Grade Level Readability Score

FRE - Flesch Reading Ease Readability Score

GLBTQ – Gay/Lesbian/Bi-sexual/Transgender/Questioning

HIV – Human Immunodeficiency Virus

HR – Harsh Reality

IDU – Intravenous Drug User

MB - Manitoba

MDGs – Millennium Development Goals (from United Nations)

MERC – Magnus Eliason Recreation Centre

MSM – Men who have Sex with Men

NA – Not Available

NGO – Non-Governmental Organization

PHAC – Public Health Agency of Canada

PSR – Passive Sentences Readability Score

PTSD – Post Traumatic Stress Disorder

RaY – Resource Assistance for Youth

SERC – Sexuality Education Resource Centre

SIV – Simian Immunodeficiency Virus

STD – Sexually Transmitted Disease

STI – Sexually Transmitted Infection

TERF – Transition Education Resources for Females

U of W – University of Winnipeg

UDEA – Universidad de Antioquia

UM – University of Manitoba

UN – United Nations

UNAIDS – Joint United Nations Program on HIV/AIDS

UNICEF – United Nations Children's Fund

Chapter One - Introduction

1.1 Defining Moments

The bent cardboard box, decorated with drawings of red AIDS awareness ribbons, sat upon the corner of the desk in the crowded classroom. The words "question box" were written in cursive across the side, and a large slit had been created in the crumpled lid to allow anonymous questions to be submitted. It was the first week of an AIDS (Acquired Immune Deficiency Syndrome) education program for youth in the bustling city of Arusha, Tanzania. The plan was for our group, a mishmash of North-American volunteer interns, to deliver educational programming about AIDS to adolescent peer educators. These peer educators, upon return to their respective neighbourhoods, would share their knowledge about AIDS prevention with their classmates, friends, and families. Ideally, the dissemination of this knowledge would help to mitigate the spread of AIDS in some of the local communities.

Under the supervision of Global Service Corps, a non-governmental organization who recruited volunteers via the internet, the group of approximately twenty interns had arrived in Arusha in two waves; the second group arriving two weeks after the first. As a member of the second group comprised of six people, upon our arrival I was disappointed to learn that all of the lesson and activity planning had taken place in the two weeks prior to our arrival. Almost all activities and lessons for the duration of the three-week program were taken directly from an existing manual that, from what I remember of the explanation, was based largely on a Peace Corps AIDS Education manual. The selected lessons, chosen by the first group of interns during the initial two weeks, were based almost exclusively on what supplies were available from Global

Service Corps. If a lesson included an activity that required tape to stick papers to a wall and there was no tape available, an alternate lesson that did not require tape was selected. The availability of supplies seemed to overshadow other considerations, such as value of the content of the lesson, and sequencing of information presented.

Fresh from finishing my Bachelor of Education degree, I was eager to put into practice some of the strategies such as differentiated instruction, cooperative learning, and creative assessment, which I had been learning about for the past two years. As the only intern with an education background amidst a group of pre-med science and nursing students, I hoped my enthusiasm for being involved with an AIDS education program would compensate for my skepticism regarding some of the lesson plans; most of which were teacher-directed, and quite a few relying on rote memorization of AIDS related facts. I felt a bit stifled that the group seemed reluctant to entertain the possibility of deviating from or modifying the scripted lesson plans. Feeling as if I had the most limited AIDS-related knowledge, and new to the dynamic of the group, I was reluctant to strongly advocate for changes I thought could improve the lessons.

At the suggestion of an intern who had experience with quantitative science research, plans developed to conduct an initial multiple-choice assessment with the peer educators to serve as a baseline for a simple pre and post test design. In a brainstorming session, the entire group of interns came up with a series of questions pertaining to a range of AIDS related topics, such as modes of transmission, forms of prevention, and biology of the disease. The questions were drawn from what the interns thought would be important, not necessarily from the lesson plan objectives that would direct the program. The initial assessment also included questions about the sexual activity of the

peer educators, such as their age of sexual debut, number of partners, and frequency of condom use.

The first day of the program arrived and the benches of the classroom were lined with adolescents, aged 13–18, sporting freshly washed school uniforms and looking refreshingly eager to give up three weeks of their summer holidays to attend a voluntary education program. After brief introductions by the twenty interns hovering at the front of the room, the initial assessments were distributed throughout the classroom. Time passed. Papers rustled and occasional whispers were heard between the peer educators. More waiting. The interns looked at each other perplexed; the one page assessment was not intended to take this long. Students' hands began to rise, but questions were not directed towards the interns. Rather, individuals who spoke both Swahili and English were summoned to desks and asked to translate the questions into Swahili. It became apparent that language comprehension posed a significant barrier in completing the assessments. Fortunately, we were able to use a fabulous English/Swahili translator for the remainder of the peer education program, and he went through all of the assessment questions aloud. Afterwards, the assessment sheets were collected. I believe that the results were tallied and put into a spreadsheet by a few of the interns, but to my knowledge, they were not used to direct future lesson plans. I do not recall if a final assessment was done at the conclusion of the program. If it was, the results were not widely disseminated throughout the group of interns.

Our lessons for the first week were, for the most part, introductory. Our group of interns informally divided into "leaders" and "helpers". The "leaders" did the talking and explaining of lessons. The "helpers" wrote down key points on the board and

handed out supplies. I was a "helper". During the first few lessons, we discussed modes of transmission such as exchange of blood and bodily fluids. We talked about the ABC's of prevention and wrote them on the board: Abstinence, Be Faithful, and Condom use. With peer educator input, we divided statement cards such as "sharing a toilet", "being bitten by a mosquito" and "having unprotected sex" into "risk of transmission" and "no risk of transmission" piles.

The content of the lessons themselves was fine. Although, at times, it appeared that some of the interns became caught up in flexing their academic muscle. This took the form of sharing more advanced information than the introductory nature of the lesson required, such as explaining the eight different strands of the Human Immunodeficiency Virus (HIV), and the theory of HIV evolving from Simian Immunodeficiency Virus (SIV) in primates. While I certainly learned more about AIDS from these additions, at times, the information presented seemed to be more to impress the other interns than for the benefit of the peer educators.

One lesson which took place towards the end of the first week was particularly memorable. My desire to maintain a positive attitude could not disguise that the lesson of the day had been well-intentioned, but less than successful. The goal of the lesson was to teach the peer educators about the value and use of female condoms (which were extremely scarce in Tanzania). This lesson, while not one of the lessons from the manual, had been incorporated at the suggestion of an intern who had brought a giant box of female condoms with him. To this end, the students had spent the majority of the morning watching an intern perform multiple demonstrations of inserting a female condom into the opening of a water bottle and encouraging the peer educators to

imagine the bottle was a vagina. In response to the quizzical faces, the intern attempted to clarify the demonstration with repeated pointing at the water bottle and encouraging female youth to "imagine this is inside of you." Unfortunately, not even the assistance of the English-Swahili translator seemed to make the demonstration more clear.

While this demonstration was abstract at best, the extent to which the lesson, and our programming in general, had missed the mark became apparent when it came time to open the question box at the conclusion of the first week. The question box had been introduced on the first day of the program. Peer educators were encouraged to submit anonymous questions into the box either during program, or outside of program time. Amongst the interns, there had been some general speculation about what questions might arise when we opened the question box. A curly-haired intern from the Midwest wondered if her explanation of the different strands of HIV might have caused any lingering questions. Another wondered if his introduction about the different types of anti-retroviral drugs was lacking in sufficient explanation.

In the few minutes before the interns and peer educators walked to an adjoining classroom for our daily snack of bananas and tea, one of the interns suggested answering a question or two from the question box while the tea water was boiling. I distinctly remember the first question that was read because it continues to be one of the defining moments in my career as an educator. The curly-haired intern unfolded the paper and read aloud "when do boys begin to menstruate?" Initially, there were a few smirks amongst the interns who wondered who had put the question in the box as a joke. But as we looked out at the students' expectant faces – it became evident that this question was not submitted in jest. While some of the students in their older teens knew the answer,

many of the younger students, and indeed a few of the older, had never been offered access to basic information about their own bodies. I would later learn that at the schools from which these peer educators were recruited, there was no existing health curriculum, nor were lessons about health, particularly sexual health, a component of their schooling. This was especially concerning in light of the prevalence of HIV in the community. In the vicinity of the school, community health providers had estimated the prevalence of HIV at approximately one in four.

The questions from the box continued: "What does sex feel like?", "Can having sex give you cancer?", and "Can you get pregnant from anal sex?" Our week of lessons debating how many liters of saliva might constitute a "risky bodily fluid" for HIV transmission and explaining the correct usage of female condoms was so far removed from the life experiences and existing knowledge of these learners. How could these adolescents be expected to understand that condoms can prevent the spread of HIV if they learned only the names of bodily fluids, but not what the terms actually meant? How could they be expected to understand that you can't "catch" AIDS from sharing a toilet with an infected person, if they didn't understand how the virus enters the body?

I reference this as a defining moment in my career as an educator because at that moment, the necessity of knowing one's learners was indisputable. The lessons from the manual had valuable content; I learned more about AIDS from them, and they might have worked very well in a different classroom context. However, the content of those lessons was not immediately relevant to the context of the learners in that specific AIDS Education program.

The question box, while initially implemented as a "time filling" activity, in my opinion, became the driving force behind the education program. The questions provided a snapshot into the students as learners and the issues they cared about. During the course of the three-week program, no student submitted a question about the different strands of HIV. However, many asked questions about common misconceptions such as whether having sex with a virgin could cure AIDS, or if washing with alcohol after unprotected sex could negate the risk of transmission. It became apparent that for a health education program to be effective it requires several key ingredients: the information presented must be compatible with the learners' existing knowledge, the information presented must be accurate and factually based (and drawn from sources which the learners deem as credible), and the information must be grounded in issues which are important and relevant to the learner.

Community education projects can be of great value, but education programs, even well-intentioned and well-developed programs, are not "one size fits all". In a country with one of the highest prevalence rates of HIV in the world, an AIDS education program for these peer educators was not just an opportunity to occupy idle children during their summer holidays. Without hyperbole, access to relevant and contextually appropriate health information had the possibility of saving lives. Access to knowledge about one's own body and one's own health should not just be a luxury afforded to some, but a fundamental human right.

1.2 Personal Involvement in the Research

My involvement in the research described in this paper has taken two forms; that of a research assistant, and that of a graduate student. In September 2008, I began the Master of Education program at the University of Manitoba. As a result of my internship in Tanzania, and a subsequent internship as an AIDS Educator for CAUSE Canada/Canadian International Development Agency in Sierra Leone, my application to graduate school expressed my interest in exploring the role of education in the prevention of HIV/AIDS. Due to my areas of interest, upon acceptance, I was placed in the Curriculum, Teaching and Learning Stream within the subject area of Science.

A few months later, via the connections of my advisor, Dr. Barbara McMillan, I was fortunate to be introduced Dr. John Wylie, an associate professor at the University of Manitoba and distinguished HIV/AIDS researcher for the province of Manitoba. Dr. Wylie explained that an evaluation of *Harsh Reality*, a sexual health resource for street-involved youth, was going to be undertaken and asked if I would be interested in assisting with the data collection and evaluation of the resource. Of course, I welcomed the opportunity to become involved with a project that combined my background in education with my interest in AIDS prevention and education. I was hired as a research assistant for the University of Manitoba, Department of Medical Microbiology, to undertake this task.

It is through my employment as a research assistant that the data collection for the evaluation of *Harsh Reality* took place. Dr. Wylie generously consented that the evaluation data could also be analyzed and used as the basis for my Master's thesis. For this reason, I was fortunate that, in addition to being able to analyze the data from the

Harsh Reality evaluation for my thesis, through my employment as a research assistant, I was also able to gain the invaluable experience of going out into the community to collect the data. The implications of these two roles, such as obtaining ethical approval, will be further discussed in Chapter 3.

1.3 The Scope of AIDS: Globally and Locally

Since the red AIDS awareness ribbons created by Visual AIDS Artist Caucus burst into mainstream celebrity fashion in the early 90's, the issue of HIV and AIDS has emerged as a mainstay in popular dialogues about sexual health. This emergence into mainstream consciousness occurred almost ten years after the first case of AIDS was reported on June 5, 1981 by the Centre for Disease Control in Atlanta, Georgia (Whiteside, 2008, p.1). In the three decades since that first case was reported, concerning rates of new HIV infections and AIDS related deaths have continued to garner international attention. The United Nations Acquired Immune Deficiency Syndrome Report (UNAIDS, 2008), a widespread synopsis of the 164 commonwealth countries which make up the United Nations, estimates that in 2007 alone, 370,000 children under the age of 15 became newly infected with HIV (UNAIDS Report, 2008, p.8). Furthermore, in a number even more staggering than the annual number of new infections, UNAIDS estimates that, worldwide, there are between 30 and 36 million people living with HIV (UNAIDS Report, 2008, p.5). To put the statistic in perspective, globally, there are more people living with AIDS than the entire population of Canada.

While the impact of HIV and AIDS is expansive and still at epidemic levels in many countries, it is important to recognize and celebrate positive milestones in

combating the disease. Progress has certainly been made in providing access to antiretroviral medication, the medication which helps to control the HIV virus in the body. In recent years, the number of people receiving antiretroviral medicines in low and middle income countries has increased ten-fold (UNAIDS Report, 2008, p.17). However, despite the positive achievement of greater access to antiretroviral drugs, this achievement has also contributed to an increase in a less-favorable statistic. As a result of the ongoing numbers of new infections each year, in addition to greater access to antiretroviral therapy prolonging the life of those with HIV, overall "the global number of people living with HIV/AIDS has increased" (UNAIDS Report, 2008, p.5).

For many people, the continent of Africa is synonymous with the topic of AIDS. While Africa is certainly not the only nation affected, some regions of Africa have borne the lion's share of the global epidemic. The countries which comprise sub-Saharan Africa remain the "most heavily affected by HIV, accounting for 67% of all people living with HIV, and for 72% of AIDS deaths in 2007" (UNAIDS Report, 2008, p.5). While sub-Saharan Africa is most heavily affected, other nations of the world, including Canada, are not beyond the reach of the HIV virus.

Canada is fortunate to be in the company of other countries such as Australia, Mexico, Spain and Greenland, with some of the lowest reported prevalence of national HIV rates – estimated between 0.1% and < 0.5% (UNAIDS Report, 2008, p.5). Moreover, the annual number of HIV cases in Canada has remained relatively stable over the past decade (Public Health Agency of Canada, 2010, p.15). While this prevalence seems encouragingly low, it is not without its casualties. Since the Public Health Agency of Canada first began recording AIDS cases in 1979, up until December

31st, 2009 there has been a cumulative total of 21,681 AIDS cases reported to Public Health Agency of Canada (PHAC) (Public Health Agency of Canada, 2010, p.8). This number of cases must be interpreted with the consideration that this statistic only reflects the number of individuals who have been identified as having HIV, and does not speak to the persons who may be infected but not seeking, or unable to access, HIV testing.

HIV does not present with a uniform prevalence throughout all sub-groups of Canada's population. In fact, throughout the world, with the exception of sub-Saharan Africa, "HIV disproportionately affects injecting drug users, men who have sex with men, and sex workers" (UNAIDS Report, 2008, p.9). Canadian statistics show that individuals who engage in these high-risk behaviours are indeed at higher risk of contracting HIV. In Canada, though HIV infection attributed to men having sex with men (MSM) has decreased from 80% in 1985 to 41.8% in 2009, MSM is still the predominant exposure behaviour for new cases of HIV (Public Health Agency of Canada, 2010, p.3). In addition to men having sex with men, heterosexual contact, followed by injection drug use, are the top three methods of transmission in new HIV cases (Public Health Agency of Canada, 2010, p.3).

Similarly to how specific behaviours correlate with higher incidences of HIV infection, certain age ranges also display a higher number of HIV cases. Globally, the age group between 14-24 years comprises the largest group of new cases, accounting for 45% of new HIV infections (UNAIDS, 2008, p.13). However, this is not congruent with the trend in Canada. The most recent data available from the Public Health Agency of Canada indicates that that the majority of new AIDS cases reported in 2009 presented in individuals between the ages of 40-49 (38.8%), followed by those between the ages of

30-39 years (28.6%) (Public Health Agency of Canada, 2010, p.8). Overall, individuals between 30-39 years remained the largest age group among all Canadian HIV case reports (30%) followed closely by individuals between 40–49 years (29.9%) (Public Health Agency of Canada, 2010, p.4). The Public Health Agency of Canada's report, *Canada and AIDS* (2010), describes that "the trend in the proportion of HIV positive cases among older Canadians has been more-or-less increasing since reporting began in 1985" (2010, p.15).

However, this trend does not necessarily mean that older Canadians are acquiring more new cases of HIV. Instead, perhaps older Canadians are being tested with increasing frequency. PHAC acknowledges that "surveillance data can only tell us about persons who have been tested and diagnosed with HIV or AIDS and not those who remain untested and undiagnosed" (Public Health Agency of Canada, 2010, p.1). The *Canada and AIDS* document also raises the point that "because HIV is a chronic infection with a long latent period, many persons who are newly infected in a given year may not be diagnosed until later years" (Public Health Agency of Canada, 2010, p.1).

Just as HIV prevalence is not uniform throughout various age groups, it also does not display uniform prevalence among different ethnicities. Among Canadian positive HIV test reports containing gender information and collected between 1985 – 2008 (all ages), positive male cases were primarily Caucasian (69.8%), with a minority of Aboriginal (15.5%) and Black individuals (5.7%). Among females, on the other hand, cases were split almost equally between Caucasian (38.2%) and Aboriginal persons (40.3%), while Black individuals represented 16.9% of total cases (Public Health Agency of Canada, 2009, p.7). However, it is important to note that these positive test

results may have been influenced by one of more contributing factors, such as some ethnicities having greater accessibility to HIV testing facilities, or some ethnicities possibly engaging in more high risk behaviours and therefore seeking testing with more frequency.

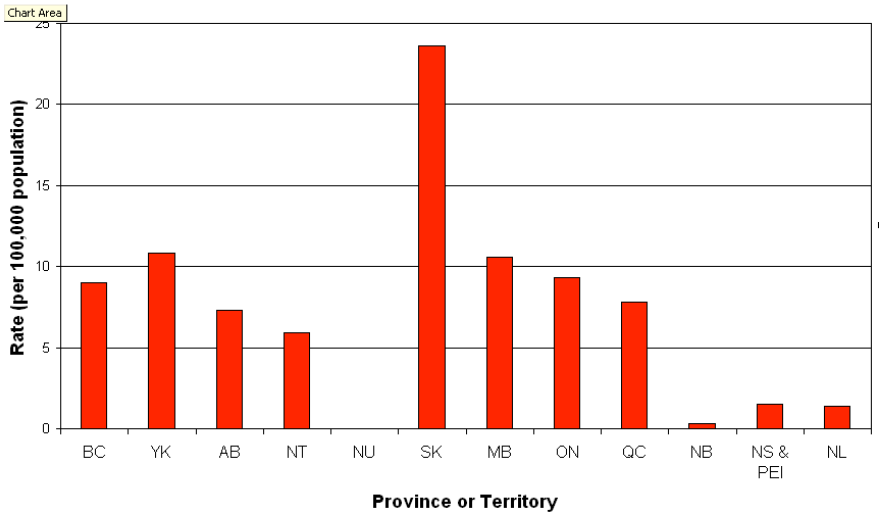
This was certainly the case for the data presented in *Canada and AIDS,* wherein different risk factors presented as more or less prevalent for different ethnicities. For example, individuals who participated in an HIV test and who self-identified as Black had the highest proportion of HIV attributed to heterosexual contact (Public Health Agency of Canada, 2010, p.6). Individuals who participated in an HIV test and who self-identified as Latin American had the highest proportion of HIV rates attributed to MSM than any other ethnic category (Public Health Agency of Canada, 2010, p.7). Individuals who self-identified as Aboriginal had the highest proportion of HIV reports attributed to injection drug use (Public Health Agency of Canada, 2010, p.6). The chart, *Proportion of positive HIV test reports, by ethnic status and exposure category, 1998-2009*, included in *Canada and AIDS*, details the differing exposure categories for various ethnicities in Canada (Public Health Agency of Canada, 2010, p.7).

However, these statistics must be considered with the knowledge that individuals who were tested were asked to self-identify the high risk behaviours in which they had participated. It is possible that individuals might withhold disclosing participation in behaviours they felt could be perceived unfavorably by a questionnaire administrator. With the exception of Quebec, which does not record exposure category of HIV tests, only slightly more than half of the HIV tests completed in Canada in 2009 included information about exposure category (54.7%) (Public Health Agency of Canada, 2010,

p.3). Further, the provinces of Quebec and Ontario do not submit any ethnicity information with their HIV tests. This omission also influences an accurate interpretation of which exposure activities may be prevalent in different ethnicities.

Similarly to how HIV does not exhibit a consistent incidence across all global geographic regions, HIV in Canada does not present a standardized prevalence throughout the various provinces and territories. The following graph, based on data included in *Canada and AIDS*, illustrates the various rates of positive HIV tests in 2009 across Canada.

Figure 1.1 Rate of positive HIV test reports among adults (over 15 years) by province in 2009



(Based on information from Public Health Agency of Canada, 2010, p.30)

As represented in the graph, the highest rate of HIV test reports among adults is in Saskatchewan (23.6%), which is approximately three times the national rate of 8.6%

(Public Health Agency of Canada, 2010, p.30). The Yukon has the second highest rate with 10.8% and Manitoba is a very close third with 10.6% (Public Health Agency of Canada, 2010, p.30). Within Manitoba, it is also noteworthy that the majority of cases of HIV between the years of 1985 and 2007 have been concentrated within the city limits of Winnipeg (84%), and not in rural areas or from individuals who have traveled to Manitoba from alternate provinces or territories (Public Health Agency of Canada, 2009 p.3). It is not clear if this statistic displays a higher concentration of positive test results because there is actually a higher HIV prevalence in Winnipeg, or if this can be attributed to individuals having more access to testing facilities within the city limits.

In his book, *HIV/AIDS*, Alan Whiteside boldly states that "a person who is HIV positive has almost certainly had sex with someone who is infected" (Whiteside, 2008, p.121). While this statement does not ring true for cases of mother to child transmission, reflected in both global trends and trends within Canada, sex with an infected person is the primary method of new infection with HIV (Public Health Agency of Canada, 2010). Therefore, an integral step in developing effective AIDS education programming is determining the populations who are frequently engaging in unprotected sex, then assessing what those individuals already know, what they want to know, and how the appropriate information can be presented in a way that is relevant, accurate, retainable and, ideally, able to affect positive behavioural change. One such population is street-involved youth.

1.4 Street-Involved Youth: "Not Visible" or We're Just Not Looking?

In the widely acclaimed book *Moving mountains: The race to treat global AIDS*, Anne-Christine D'Adesky touches upon the idea of AIDS prevention programs and is quick to point out their limitations and shortcomings. D'Adesky notes that

> In countries where innovative prevention programs are funded, they are usually small-scale, and target communities at high risk, such as sex workers, drug users, or men who have sex with men. But they fail to reach married women or street children – groups who are very vulnerable to HIV but may not be as visible. (D'adesky, 2004, p.270)

As D'adesky points out, one of the largest challenges in accessing the street-involved population is their visibility. In temperate climates, street-involved youth may be consistently visible throughout the year in areas such as drop-in centers, public parks, and public venues. However, in Winnipeg where at least four months of the year can be extremely cold, street youth are much less visible – particularly during the winter months. Instead of congregating at popular outdoor meeting places, or bus shelters, or under a bridge - many choose to "couch surf", staying at a friend or acquaintance's house, or to "squat", staying illegally in a building or public venue. Some homeless youth, often identified as "travelers", ride trains to more temperate areas of Canada until temperatures become less extreme. This transience and resulting reduced visibility of youth can make offering services, educational resources, and/or treatment challenging. However, although possibly more challenging to locate, I would argue that street youth are, in fact, visible; one just needs to learn where to look.

In a city of just over 660,000 people, Manitoba's capital city of Winnipeg is estimated to have approximately 2,000 people who are homeless (Siloam Mission, 2007, General Information section ¶1). There are many risks associated with being homeless, but these risks are especially heightened for homeless youth, including "high rates of drug abuse, incarceration, unemployment, school drop-out, and mental health problems" (Arnold & Rotheram-Borus, 2008, p.76).

While the definitions of homeless youth will be discussed in greater detail in Chapter 2, a preliminary definition of homeless youth includes young people between the ages of 14-24, from every ethnic background, who "lacking a fixed, regular and adequate nighttime residence, live with friends or acquaintances, in shelters or other system-based institutions, in unstable residences, or on the street" (Taylor-Seehafer, Johnson, Rew, Fouladi, Land & Abel, 2007, p.38). While the homeless or street-involved youth demographic is not identified specifically as the group with the highest rate of new HIV infections in Canada, this may be because street-involved youth are one of the least likely groups to seek out HIV testing.

There are many health challenges associated with being street-involved, and in particular, one such challenge is elevated rates of sexually transmitted infections (STI) (Ensign & Santelli, 1997; Rew, Chambers & Kulkarni, 2002). In the *Respondent-driven sampling in street-involved youth study* facilitated in Winnipeg in 2007, in a sample group of 160 street youth (half male, half female), the rate of chlamydia and/or gonorrhea was 15%, which the study reported "is much higher than for youth in general in Manitoba, and for other 'street-involved youth' across Canada" (Thompson, Schellenberg, Ormond & Wylie as per *Harsh Reality*, 2008, p.60). This high rate of STI

infection places these youth at heightened risk for contracting HIV because the sores or abrasions resulting from one STI can often facilitate easier exchange of bodily fluids during sexual activity. The same study found that participants described rarely using condoms during sexual activity (Thompson et al., as per *Harsh Reality,* 2008, p.60).

These findings are not limited to street-involved youth in Winnipeg alone. Mary-Jane Rotheram-Borus has spent much of her career researching and writing about street youth in the United States. Her studies corroborate the findings of elevated levels of STIs amongst street youth as found in the Winnipeg study, and her research also indicates that "the rate of HIV infection among homeless youth is substantially higher than the national rate for youth" (Arnold & Rotheram-Borus, 2008, p.76). So why, then, are street-involved youth not at the top of the priority list for receiving HIV/AIDS prevention education? Perhaps it is the issue of visibility and accessibility which provides the most difficult barrier to overcome.

Particularly in light of the different risk activities that are undertaken by different ethnicities, genders, and ages of individuals, numerous studies suggest that education and prevention initiatives must be targeted towards specific sub-groups of the population (Whiteside, 2008; Ensign & Santelli, 1997, Rotheram-Borus, O'Keefe, Kracker & Foo, 2000). My experience with the peer educators in Tanzania taught me that context is of paramount importance when sharing information with someone. Recognizing the context of street-involved youth and creating educational programming that is congruent with that context is imperative in order to facilitate AIDS prevention for this at-risk demographic.

1.5 Existing Sexual Health Educational Resources for Youth

The eight Millennium Development Goals (MDGs), set forth at the United Nations' Millennium Summit in 2000 were admirably ambitious. In addition to lofty aspirations such as universal access to primary education and an aggressive reduction of the global incidence of maternal mortality, the sixth goal aimed to "have halted by 2015 and begun to reverse the spread of HIV/AIDS" (United Nations, 2010, p.40). In supporting annotation, this sixth goal was fleshed out in greater detail, including the target of providing the population aged 15–24, with comprehensive and correct HIV/AIDS-related knowledge "which is still unacceptably low in most countries" (United Nations, 2010, p.41). In a separate global summit held in 2001, the United Nations created the *Declaration of commitment on HIV/AIDS* which established the goal that 95% of young people would have comprehensive HIV knowledge by 2010 (UNAIDS Report, 2008, p.13). The key word used in both goals is "comprehensive". As I have experienced in my work within the field of AIDS education both in Canada and abroad, the problem is not a lack of information about AIDS; what is lacking is *accurate* and *comprehensive* information about AIDS.

Amongst other pressing global health concerns such as malaria, tuberculosis, and maternal mortality, "at the moment, HIV/AIDS is the global health issue receiving the most attention and funding" (Whiteside, 2008, p. 102). However, in spite of occupying centre stage in the global health arena, the *UNAIDS report on the global AIDS epidemic* acknowledges that "although young people, 15–24 years of age account for 45% of all new HIV infections in adults, many young people still lack accurate, complete information on how to avoid exposure to the virus" (UNAIDS, 2008, p.13). Data from

the 64 countries who participated in the study indicated that only "40% of males and 38% of females ages 15-24 had accurate and comprehensive knowledge about HIV and about how to avoid transmission" (UNAIDS Report, 2008, p.13). D'Adesky acknowledges the inherent challenge some individuals face in accessing information about AIDS, and describes that "globally, fewer than 1 in 4 people at risk from HIV is able to access basic information about the disease" (D'Adesky, 2004, p.270). The UNAIDS report continued to explain that "young females are notably less likely than young males to have an accurate, comprehensive knowledge of HIV" (UNAIDS Report, 2008, p.14). This is most likely due to females being less-likely to attend school than males in many regions of the world.

The enormous benefit that access to education can provide, in terms of quality of life and specifically in relation to the global AIDS epidemic, is a central idea throughout Stephen Lewis's book *Race against time: Searching for hope in AIDS ravaged Africa* (2005). Stephen Lewis, a prolific Canadian who, amidst a lengthy list of both national and international accomplishments, served as the United Nations Secretary-General's Special Envoy for HIV/AIDS in Africa from 2001–2006, is unrepentant in his advocacy for access to education. In the chapter "Education: An avalanche of studies, little studying", Lewis makes reference to a statement from the former executive director of UNICEF, Carol Bellamy, who expressed that

> Placing every child in a classroom has never been more urgent than it is today. Under threat from the pandemic, children must be able to turn to schools as places of learning, inclusion, stability, and life saving information about HIV/AIDS. (Lewis, 2005, p.74)

In developing contexts, such as Africa, traditional classrooms often provide the link for access to information about HIV/AIDS. In more developed contexts, such as Canada, in addition to information provided within schools, there is also a wide range of information available to the public outside of the classroom. In Manitoba, for example, there are a variety of resources which are available, both in print and online, to educate teenagers and young adults about the prevention of STI and, in particular, about the prevention of HIV/AIDS. However, finding resources which are tailored toward youth within the context of Manitoba and, more specifically, toward street-involved youth in Manitoba, is much more challenging.

The Sexuality Education Resource Centre (SERC) in Winnipeg is often recommended by health care and youth service providers as a resource for youth. SERC's website offers a link to "SERC for Youth" (Sexuality Education Resource Centre, 2005, SERC for youth section). The "SERC for Youth" link directs the user to the online pamphlet *Think Again.*

The *Think Again* campaign, funded by Healthy Child Manitoba, began in 1998 as an initiative to "encourage teens and their friends, partners, and families to discuss relationships, decision making and other issues related to teen pregnancy, sexually transmitted infections and HIV/AIDS prevention" (Think Again, 2008, About the Campaign ¶ 2). The description does not specify if the *Think Again* resource is targeting any particular segment of the youth population in Manitoba. The site further describes that a "youth creative team" was formed in order to move "toward updating the resources with a more positive, current look" (Think Again, 2008, About the Campaign ¶ 3). Within the pamphlet, there is information about pregnancy, a list of clinics and

community health service providers, and a "mythbuster" section that offers statements such as: "A LOT can be felt through condoms" and "Less than 50% of High School students have had sex" (Healthy Child Manitoba, 2005, p.1). There is also a robust section on what questions to ask yourself if you are thinking of having sex, such as "Do I feel pressured?" and "Does having sex fit with my beliefs?" (Healthy Child Manitoba, 2005, p.2).

However, there is no information in the pamphlet about types of sex that someone might not choose, such as survival sex, or where to seek help in the event of sexual exploitation or rape. Furthermore, the pamphlet does not contain any information about sexuality. *Think Again* is attractively designed, with photographs of a heterosexual couple holding hands in addition to a list of various forms of birth control. While this pamphlet might be useful for mainstream youth, the appearance seems too neat, and perhaps too tightly packaged, to appeal to a street-involved youth population.

An electronic version of the print resource entitled *Little Black Book* is also available on the SERC website. Interestingly, while the *Think Again* pamphlet is the only resource available under the tab "SERC for Youth", the *Little Black Book* is available under the heading "Additional Resources" in the "SERC for Service Providers" tab (Sexuality Education Resource Centre, 2006, SERC for Service Providers section). I have never physically come across a copy of the *Little Black Book*; however, several individuals who were aware of my area of study asked if I was familiar with the resource. The *Little Black Book* is an address book, 116 pages in length, which also includes full page posters about a variety of health and well-being topics, such as STI, careers, substance use, labor law, and smoking. Within the book, there are

approximately the same number of pages for recording addresses and contact information as there are pages of full page posters (48 pages and 53 pages, respectively). Almost all of the address pages display single sentences, addressing a host of topics, at the top of the page. For example, some sentences include:

- "You wouldn't let someone at a party do dental work on you, so why let them give you a tattoo or piercing?" (Sexuality Education Resource Centre, 2007, pg 5)
- "If you have ever had vaginal, anal, or oral sex, you are at risk for STIs." (Sexuality Education Resource Centre, 2007, p.17)
- "Life is worth raving about. If you rave, rave safe!" (Sexuality Education Resource Centre, 2007, p.39).

While a variety of topics are covered, the theme that appears with the most frequency, 12 of the 49 sentences, pertains to sexual health and STI.

The *Little Black Book* is described as being for "students in grades 9–12" and "was developed by youth for youth" in order to increase "young people's ability to access information and community resources" (Sexuality Education Resource Centre, 2006, For Service Providers, Additional Resources ¶ 1). The closing credits acknowledge that the *Little Black Book* was created by the "S-Team" in conjunction with the SERC office in Brandon (Sexuality Education Resource Centre, 2007, p.115). The SERC website describes that the "S-Team" is "a group of youth formed through the "Empowering Rural Youth Towards Healthy Sexuality Project" based at the Brandon SERC office (Sexuality Education Resource Centre, 2006, For Service Providers, What's New ¶1). The "S-Team" ("SERC Team" or "Sex Team") is an ongoing group

that "offers peer education workshops to rural youth on sexual health, drug and alcohol use, and HIV/STI prevention" (Sexuality Education Resource Centre, 2006, For Service Providers, What's New ¶3).

One attribute of the *Little Black Book* that makes it stand out from other existing resources for Manitoba youth is its use of humor. Instead of simply presenting statistics, several of the posters incorporate humor, which could appeal to youth. For example, one poster includes the heading "Chlamydia is not a flower" (Sexuality Education Resource Centre, 2007, p.52) over the picture of several brightly coloured daisies. Another displays a cartoon of someone bungee jumping with a caption that reads "This is a bungee cord. It's made of rubber and it will save your life when you take that adrenaline pumping plunge into the great unknown…this is a condom" (Sexuality Education Resource Centre, 2007, p.6)

While this resource may be well-received by the Manitoba student population between grades 9–12, it may be more challenging to ensure a fit between this resource and the street-involved population. Topics such as safe sex, alcohol use, pregnancy, piercings and tattoos, suicide prevention, nutrition, and the resource lists at the back of the book would certainly be of use to street-involved youth. However, some of the topics included may send the message that this resource is only for middle-class youth. For example, one of the title pages asks the questions "What are you going to do after graduation? What road will you take? More school? Work? Travel?" (Sexuality Education Resource Centre, 2007, p.3). This series of questions is based on a number of assumptions: that the individual reading the resource attends school, that the individual

will graduate, and that the individual has a certain degree of freedom to choose if he would like to go to school, have a career, or travel the world.

Several of the informational sentences and full page posters also refer to financial security. One example encourages youth that when "using your credit card, subtract that amount from your bank account. That way you'll have the money to pay your bill" (Sexuality Education Resource Centre, 2007, p. 24 & 25). This sentence too is based on the assumption that the reader has a credit card, and/or a bank account.

Later in the resource, the "Money, money" full-page poster asks if the reader is "destitute" and suggests methods for saving money. While these methods might be useful and applicable for a middle-class youth, they are not necessarily appropriate for a street-involved youth. Clearly, the term "destitute" is relative for different youth's situations: being too "destitute" to go to the movies with your friends is quite different from being too "destitute" to obtain food to survive.

As a whole resource, the *Little Black Book* could be very valuable for students attending school in middle-class contexts. It incorporated youth perspectives and input through the involvement of the "S-Team". It is innovative in that the resource combines an address book with information about a variety of relevant topics. It does incorporate more humor and interesting images than the *Think Again* brochure. However, the inclusion of multiple topics that apply to more middle-class youth may make some street-involved readers feel isolated and stigmatized, thus impeding the potential efficacy and influence of the resource.

A third example of an existing resource is *The Teenage Survival Handbook*, a print resource I came across in one of the hallways of the University of Manitoba,

Bannatyne Campus in 2008. There was a large stack of the resources near one of the bulletin boards by the classrooms for Occupational Therapy. I am not aware who the intended audience of these resources were, nor how they got there. The graphics on the cover and supplementing the articles are eye-catching and done in the style of Manga by a freelance comic artist who goes by the name Kan –J (Raphael Pirard). The magazine is 35 pages in length, and contains information about a variety of topics, such as suicide, growth spurts, dealing with your parents, and sex, relationships, and STI.

Although the graphics appeal to youth, the magazine appears to target teachers or parents of youth instead of the youth themselves. The website of the magazine's publisher, Regional Maple Leaf Communications Inc., describes that the resource is intended to be read "with" youth aged 12–16, as opposed to be given "to" youth (Maple Leaf Communications Inc., *The Teenage Survival Handbook* section ¶1). The print resource itself offers an introductory "message to parents and teachers", while there is no introductory message directed toward youth (Regional Maple Leaf Communications, 2008, p.2).

Another striking element of the magazine is the volume of corporate advertising. Within the 35 pages, there are 187 corporate advertisements, ranging from decorative sandblasting and day spas, to pet spay and neuter clinics. Of the 187 advertisements, there are only three which specifically offer teen services: Mount Carmel Clinic, Onashowewin Restorative Justice Program, and the Manitoba Metis Federation. The lack of advertising directed toward youth is further evidence that youth themselves are not the target audience of this resource.

While the headings of the various articles appear to be suitable for street-involved youth, upon reading the content, it quickly becomes apparent that this resource is intended for youth who are not participating in high risk behaviours. For example, in the article "Romeo and Juliette *(sic)*: Sex, relationships and STIs*"*, the handbook states "the law says we are not adults until we are at least eighteen. We're not allowed to drink alcohol before then, SO HOW CAN WE BE THINKING ABOUT HAVING SEX???!!!" (Maple Leaf Communications, Inc., 2008, p.21).

The Teenage Survival Handbook also seems to fall into the familiar pitfall of over-endorsing abstinence as the best option. In regards to sexual behaviour, the *Teenage Survival Handbook* cautions youth "don't rush...You only get one first time and once you use it, it's gone forever" (Maple Leaf Communications, 2008, p.25). Jessica Valenti, an avid feminist author and lecturer, discusses at length the heightened importance many sexual education programs place on virginity, particularly for adolescent girls. Throughout her latest book, *The purity myth*, Valenti uncompromisingly argues in favor of less value-laden sex education, writing:

> Young people deserve accurate and comprehensive sex education not just because they're going to have sex, but because *there's nothing wrong with having sex*. Allowing educators to equate sexuality with shame and disease is not the way to go; we are doing our children a great disservice. (Valenti, 2009, p.120)

Whiteside agrees with Valenti's sentiments, and supports the idea that "a narrow focus on abstinence and fidelity is unrealistic, hypocritical, and stigmatizing…The

emphasis should be on responsible sexual behaviour rather than scare tactics" (Whiteside, 2008, p.127).

The Teenage Survival Handbook is the kind of resource that could be readily endorsed by school divisions and distributed to students because it is "safe". It promotes abstinence, it is not too graphic, and it does not "rock the boat" by addressing any topics that are too uncomfortable. Even articles that address more serious topics shy away from really delving into the issue. For example, the article about running away offers a light comparison of teenage runaways being similar to a 10-year-old running away after becoming upset over the death of his goldfish (Maple Leaf Communications, 2008, p.17). This resource has "youth friendly" artwork, and has the titles of some topics that may be relevant for street-involved youth. However, ultimately, the "safe" nature of the resource and its inability to address some of the more challenging and gritty issues that street-involved youth have to deal with would make it a much more suitable magazine for youth in the general population.

A common theme when reading about AIDS education and prevention programs is a general consensus that no one approach will work everywhere (Whiteside, 2008; UNAIDS, 2008; Rotheram-Borus et al., 2000). Resources and education initiatives must be tailored to their target audience: in this case, street-involved youth in Manitoba. To this end, *Harsh Reality* is a health and well-being resource that was created *by* street-involved youth *for* street-involved youth.

1.6 Harsh Reality: A Different Kind of Resource

After months of brainstorming, hours of meetings, and debates over both content and layout, the fourth edition of *Harsh Reality* was printed and ready to hit the streets of Winnipeg in spring of 2008. Originally created in 2001 with the support of Kali Shiva AIDS Services, AIDS Community Action Program, and the Public Health Agency of Canada, *Harsh Reality* is a print resource (240 pages in length) aimed specifically towards the population of street-involved youth in Winnipeg. *Harsh Reality* contains topics relevant to street-involved youth, such as: health and nutrition, drugs and alcohol, mental health, gangs, and a primary focus on sexual health issues such as STI and blood borne pathogens. *Harsh Reality* is a unique hybrid of factual information, and art and written experiences submitted by local street-involved youth themselves. A youth working group, comprised of local street-involved youth, collaborated with Margaret Ormond, a research nurse with extensive experience working with street-involved populations in Winnipeg, to oversee the topics and information included in *Harsh Reality* and the physical lay-out of the resource. *Harsh Reality* was designed with the intention of being a stand-alone instructional resource with copies of the book freely circulating amongst youth.

Figure 1.2 Cover of *Harsh Reality*

(Harsh Reality, 2008, cover)

The appearance and content of *Harsh Reality* are markedly different than other print resources directed toward youth. It is eclectic with many different fonts and graphics, including graffiti from local artists. The text incorporates a substantial amount of profanity and slang. It was not put together by a slick professional graphic designer. It does not shy away from potentially uncomfortable topics such as anal sex, self harm, or mental illness. It is unlikely that *Harsh Reality* would be eagerly snapped up for distribution by school divisions for fear that conservative community parents might incite a riot. In short, the reasons why it would not be a suitable resource for the general population are the same reasons that make *Harsh Reality* an appealing and well-suited resource for street-involved youth.

1.7 Guiding Research Questions

The evaluation of *Harsh Reality* is based on two principle themes: street-involved youth's opinions of the resource; and retention of specific knowledge outcomes from the resource. The primary source of information for this evaluation is Winnipeg street-involved youth themselves, in both individual interviews or as members of focus groups (specific methodology for evaluation will be elaborated in Chapter 3). Regarding youth's opinion of the resource, the evaluation is guided by the following questions:

- What, if any, are the parts *Harsh Reality* that you liked?
- What, if any, are the parts of *Harsh Reality* that you did not like?
- What is your opinion of the layout and design of *Harsh Reality?*
- Which, if any, were the sections of *Harsh Reality* that are most useful for people your age?
- Are there any topics that *Harsh Reality* should include in future editions?

The participants' opinions about what elements of *Harsh Reality* are working well, and what elements require improvement, can help to influence future editions to ensure the resource is even more specifically tailored to the street-involved youth demographic.

As this evaluation is bounded by performing an evaluation of a sexual health resource, the outcomes of knowledge retention were all selected from the STI and blood borne pathogen chapter of *Harsh Reality.* The specific outcomes being measured are:

- Knowledge of HIV testing facilities within Winnipeg
- Knowledge of the different types of HIV tests

- Knowledge of any of the four articles (called "Research Round-Up") pertaining to prior research conducted with street-involved populations in Winnipeg

If youth are able to recall these specific knowledge outcomes, it may be deduced that the current method of presenting the information (mini-poster or article or chart) is effective. If youth are unable to recall these specific knowledge outcomes, that may encourage a change in the manner of presenting the prioritized information (such as using a bigger font, incorporating colour, or reducing the amount of text so the information is easier to find).

In addition to these research questions, youth were asked how they received *Harsh Reality* (at a youth drop-in centre, from a walk-around distribution team, from a friend, and the like), and what they did with their copy of the resource (gave it to a friend, threw it out, etc). This data will be used to influence future methods of distribution of the resource.

In trying to familiarize myself with some of the sexual health materials available for Winnipeg youth, I did not come across many that included an evaluation component. The *Think Again* brochure once offered an online evaluation component that is no longer available on the website (Think Again, 2008). However, the evaluation was intended for teachers and service providers to fill out and offer their opinions about the youth pamphlet. There was no evaluation to gain youth feedback about the resource. The evaluation of *Harsh Reality* is designed to give youth themselves a forum in which to share their opinions. In some ways, this evaluation is like opening up the question box for the peer educators in Tanzania. Instead of deciding what education information

would be a good fit *for* a particular group, it is engaging in dialogue *with* the target population that allows a rich partnership in which both educators and learners can collaborate to create a meaningful and comprehensive resource.

Chapter Two – Literature Review

2.1 The Field of Prevention

2.1.1 The definition of prevention: A work in progress.

How do you measure how often something is not happening? What if the "thing" being measured is still happening, but just not happening as often? Or, what if the "thing" is still happening, but happening in a slightly modified way? In these cases, is successful prevention taking place? How to answer these questions are just some of the preliminary theoretical challenges within the field of prevention science.

As Mary Ellen O'Connell, deputy director of the Board on Behavioral, Cognitive & Sensory Sciences points out, "the very definition of prevention is itself a problem" (O'Connell, Boat & Warner, 2009, p.14). There are a multitude of theories about and definitions of prevention which address its many facets; from who prevention initiatives should target, to how to measure if prevention is actually taking place, and the debate over the sometimes blurred line between prevention and treatment.

As a first step toward grasping the definition of prevention, it is important to consider the differences between prevention and treatment. This distinction was brought to the forefront by Dr. Gerald Caplan, a professor of Mental Health at Harvard University, and a prolific influence in the field of prevention. Caplan recognized that the large number of people suffering from mental disorders presented a "problem that we cannot hope to solve with the treatment resources available to us" (Caplan, 1963, p.1556). Something was needed to compliment existing treatment, and that initiative was prevention.

In the comprehensive document *Preventing mental, emotional and behavioral disorders among young people: Progress and possibilities* (2009), O'Connell et al. draw from the ideas of Caplan (1963) to distinguish prevention from treatment. The respective key characteristics can be summarized as presented in the following table:

Table 2.1 *Key Characteristics of Prevention versus Treatment*

Prevention	Treatment
Services are offered to the general population, or to subgroups with known vulnerabilities	Services are offered to specific people who are identified (either by themselves or by others)
People are at risk for a disorder	People are currently suffering from a disorder
People receive services with the expectation that the likelihood of future disorder will be reduced	People receive services with the expectation of receiving some form of relief from the disorder

(Based on information from O'Connell et al., 2009, p.60)

O'Connell et al. assert that "prevention occurs when communities, groups, or individuals who do not meet criteria for the diagnosis of illness, disorder, or crime receive services or interventions that reduce the chances of developing a disorder or criminal behavior in the future" (O'Connell et al. as per Hawkins, Shapiro & Fagan, 2010, p.519). O'Connell and her colleagues call for a "new emphasis on *true* prevention, which…we define as occurring prior to the onset of disorder" (O'Connell et al., 2009, p.ix). However, while Caplan identified that prevention and treatment are two distinct entities, he also proposed that there may be some overlap between the two and, in some cases, prevention initiatives can encompass elements of both prevention and treatment of a condition.

Caplan has been credited with coining the terms primary and secondary prevention. These approaches have been widely used throughout the field of public

health, and particularly within the field of mental health. Caplan describes that these are both types of prevention, and the distinguishing characteristics of the two can be summarized as follows:

Table 2.2 *Caplan's Characteristics of Primary and Secondary Prevention*

Primary Prevention	Secondary Prevention
Takes place before a condition exists	Takes place once a condition exists
Aims to lower the incidence of new cases of a disorder	Aims to reduce the prevalence of a disorder by shortening the duration of illness
Aims to reduce the risk of new incidences by lessening harmful influences, and increasing the people's capacity to avoid the illness	Aims for early diagnosis, thus cutting short the illness by effective treatment

(Based on information from Caplan, 1963, p.1556)

Eventually, Caplan also added a third category of prevention, tertiary prevention, which was "practiced after suffering or disability have been experienced, in order to prevent further deterioration" (Gordon, 1983, p.107). However, in light of Caplan's category of tertiary prevention being largely equated with treatment, this paper will focus primarily on Caplan's ideas of primary and secondary prevention. Caplan's ideas of primary and secondary prevention appeared to be accepted as the standard working definitions of prevention for approximately 20 years, until Dr. Robert Gordon's new operational classification of disease prevention was published in 1983.

Gordon's article highlighted several disadvantages of Caplan's method of categorizing prevention initiatives, notably that "the terms 'primary' and 'secondary' suggest an ordinal value" (Gordon, 1983, p.107). In Gordon's opinion, this might lead to the interpretation that primary prevention was preferable, and secondary prevention efforts were less desirable. In fact, Gordon pointed out that just the opposite might be

true, explaining that "careful quantitative analysis of benefits, costs, risks and effectiveness frequently reveals that a preventive intervention is best applied only to a high-risk group" (secondary prevention) as opposed to the general population (primary prevention) (Gordon, 1983, p.107).

Table 2.3 *Gordon's Characteristics of Universal, Selective, and Indicated Preventive Measures*

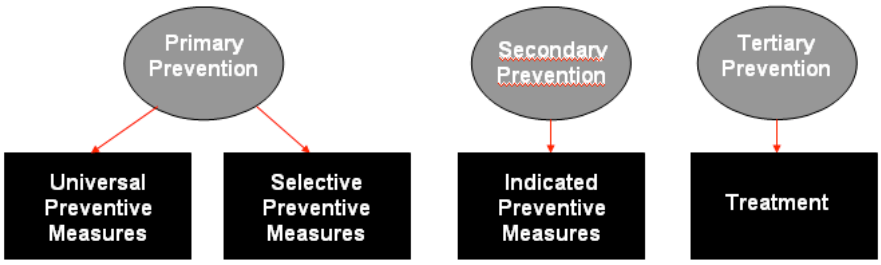
Universal Preventive Measures	Selective Preventive Measures	Indicated Preventive Measures
Strategies are offered to the full population and desirable for everybody **	Strategies are targeted to subpopulations (distinguished by age, sex, occupation or other characteristic) **	Strategies are targeted to individuals who are found to manifest a high risk *
Population has not yet experienced a problem *	Population has not yet experienced a problem ***	Individual shows early signs of a problem that is not yet diagnosed***, or is asymptomatic
Strategies likely to provide some benefit to all*	Strategies likely to provide benefit to those identified as being at elevated risk *	Strategies provide benefit to individuals with increased vulnerability based on individual assessment *
In many cases, can be applied without professional assistance **	NA	Commonly applied in clinical setting, requires professional assistance for optimal results **
Examples: maintaining a balanced diet **, not smoking, use of seatbelts in cars **	Examples: rabies vaccinations for veterinarians **, avoidance of alcohol by pregnant women **	Examples: dietary measures to control high cholesterol **, encouraging an overweight individual to lose weight to avoid heart disease

*O'Connell et al., 2009, p.61
** Gordon, 1983, p.108
*** Hawkins, Shapiro & Fagan, 2010, p.519
NA – Information not available.

Gordon also addressed that incorporating secondary prevention, which involved early detection of conditions, under the umbrella of "general prevention" could be confusing (Gordon, 1983, p.107). Therefore, Gordon suggested a new method of grouping preventive initiatives: universal preventive measures, selective preventive measures, and indicated preventive measures. The key qualities of each genre of preventive measures are summarized in Table 2.3.

Gordon specified that indicated prevention measures are distinct from treatment in that indicated prevention employs treatment of an asymptomatic, undiagnosed problem "only if it will result in the prevention of some later anticipated symptoms or disability" (Gordon, 1983, p.108). The following graphic illustrates the connection between Caplan's notion of primary and secondary prevention, and Gordon's theory of preventive measures:

Figure 2.1 The relationship between Caplan & Gordon's theories of prevention



(Based on Gordon, 1983, p.109; and Caplan, 1963, p.1556).

These methods of classifying prevention initiatives have provided the common language for professionals within the field of prevention science to implement prevention initiatives in many fields, including public health, mental health, and disease prevention. Just as the language used to describe the field of prevention has evolved and

changed throughout the years, the methods and priorities of prevention initiatives in North America have undergone similar advances and changes.

2.1.2 The evolution of prevention: A brief overview.

Much like the field of education, the field of prevention continues to evolve and change as it develops. However, compared to the well-established field of education, the field of prevention is much more recently developed. According to Brown & Horowitz (1993), in North America, the field of prevention began to take shape in the United States in the 1960's. Initially, prevention practices began within the field of prevention of mental health disorders, and were largely influenced by the work of Gerald Caplan. In subsequent years, these mental health prevention practices began to inform and influence the evolution of prevention initiatives in other fields, such as substance use, alcohol use, and communicable disease transmission (such as sexually transmitted infections).

One of the hallmarks of early prevention efforts was the development of programs "based on what [was] perceived to be a better state of affairs with little empirical evidence" (Brown & Horowitz, 1993, p.531). This is a practice which, some critics argue, is still all too common in prevention programs of today. Certainly, examples of individuals deciding, in the absence of empirical evidence, that one way of life is superior and thus imposing their lifestyle and values on others is not a practice exclusive to the field of prevention science alone. This practice has been widely implemented throughout the world and tied inextricably to colonialism. This practice continues even in modern North America, in which a program developer decides how it

"should be", and designs a program to prevent how it "shouldn't be". Within the arena of sexual health prevention, examples might include discouraging adolescent sexual behaviour (Valenti, 2009; Rotheram-Borus et al., 2000), discouraging use of birth control, or discouraging homosexuality (Valenti, 2009).

A second hallmark of early prevention initiatives, which still continues in some modern prevention programs, is the "assumption of a deviant target population" (Brown & Horowitz, 1993, p.531). The notion of "other", and the underlying assumption that these "others" need to be "saved" from their deviant behaviour can be an explicit or implicit component of prevention programs. This is different than the notion that the target population "does not know better" and therefore could benefit from education about their behaviour. The assumption of a deviant population implies that the population is exercising control over their behaviour; that they aware of and choosing their actions in spite of knowing the implications, and therefore, are willingly choosing their consequences.

Conversely, the next transformative movement within the field of prevention, harm reduction or harm minimization, set itself apart from earlier prevention theory in that it "is not based on the view of the [target individual] as a deviant" (Brown & Horowitz, 1993, p. 549). Harm reduction began to gain momentum in the United States in the late 70's and early 80's within the community of mental health disorder prevention. However, at the time harm reduction was beginning to take hold in North America, several other countries had already adopted the harm reduction theory and put the theory into action. Parts of England, Italy and the Netherlands were implementing

harm reduction programs regarding drug use, such as needle exchange programs, as early as the 1960's and 70's (Tsui, 2000, p.243).

In the article "Deviance and deviants: Why adolescent substance use prevention programs do not work*"* (1993), Joel Brown, senior evaluation scientist at Pacific Institute for Research and Evaluation, and Jordan Horowitz, project director at Southwest Regional Laboratory, describe that it was common practice for pre-harm reduction prevention programs to equate any participation in a behaviour as excessive. This was, and continues to be, particularly apparent within the field of substance use in which "there exists the constant assumption that those who use any alcohol or drugs constitute the moral equivalent of those who abuse alcohol or drugs" (Brown & Horowitz, 1993, p.541). Early prevention initiatives could compartmentalize behaviour on a checklist, and on that checklist "there are only two choices: abstention or abuse" (Brown & Horowitz, 1993, p.542).

Take, for example, the behaviour of injecting heroin. The behavioural checklist might look like this:

□ Abstain from injecting heroin □ Abuse injecting heroin

This example could be construed as a "black and white issue" because most people would argue that any instance of injecting heroin would constitute abuse of the substance. However, it becomes more difficult to use a checklist approach when the behaviour being categorized is less extreme; for example, the behaviour of consuming alcohol. The behavioural checklist might look like this:

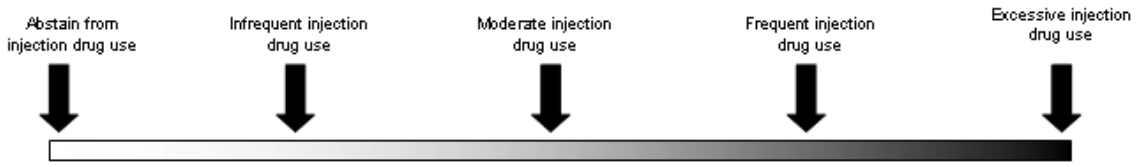
□ Abstain from consuming alcohol □ Abuse consuming alcohol

How might this checklist accommodate people who regularly have a glass of wine with dinner? Does someone who consumes alcohol once a week require the same type of prevention education or intervention as someone who consumes a litre of alcohol per day? In pre-harm reduction prevention initiatives, there was no way to account for individuals who casually, or inconsistently, participate in a behaviour. These varying degrees of participation must be taken into consideration when developing and implementing effective prevention initiatives.

Harm reduction accounts for these "grey areas" of behaviour between abstinence and excess by measuring behaviour on a continuum, not as a checklist. As Ming-sum Tsui, senior lecturer at Hong Kong Polytechnic University, describes: one end of the behavioural continuum represents excessive use, the opposite end represents abstinence, and the majority of the continuum is degrees of behaviour between the two extremes (Tsui, 2000, p.244).

An example of a continuum of behaviour representing injection drug use might look like this:

Figure 2.2 Harm reduction continuum of behaviour representing injection drug use



The language used in a harm reduction approach echoes this shift in assessing behaviour. Instead of classifying any type of behaviour that is not absolutely abstained from as "excessive", harm reduction acknowledges that an individual can participate in a

behaviour without the behaviour being abusive (such as occasional alcohol consumption). As Brown and Horowitz outline, in prevention initiatives, by textually substituting "drug abuse" for "drug use", a deviance assumption about the population is implied (Brown & Horowitz, 1993, p.541). For this reason, it is common for harm reduction prevention initiatives to refer to behaviour or substance "use", not "abuse".

Tsui elaborates that "the harm reduction approach does not equate all substance use as equally dangerous and illegal. There is some differentiation between levels of harm caused by different kinds of drugs" (Tsui, 2000, p.246). Using this approach, one is able to consider that someone who regularly uses heroin is at increased risk than someone who excessively uses marijuana.

In addition to not judging any use or participation in a behaviour as excessive, the harm reduction approach goes as far as to acknowledge that experimentation is a normative component of the adolescent experience. Brown and Horowitz argue that adolescent "problem behaviours", such as experimenting with drugs, alcohol and sexual behaviour, are actually a "developmentally appropriate form of limit testing and not indicative of an implacably deviant population" (Brown & Horowitz, 1993, p.548). This perspective has implications for prevention program development because "instead of maintaining the assumption that adolescent behaviour is maladaptive, researchers and programmers can now realistically examine an alternative prevention strategy: adolescent alcohol and drug experimentation and harm minimization" (Brown & Horowitz, 1993, p.548).

Whereas earlier prevention efforts were successful only if the individual abstained completely from the behaviour, the harm reduction approach celebrates any

progress moving towards the left side of the continuum. Continuing with the example of an individual using drugs, "the harm reduction approach aims to change the drug taker from excessive to moderate use and then to total abstinence as an ultimate goal" (Tsui, 2000, p.244).

Most literature regarding harm reduction is in regards to substance and/or alcohol use. In addition to drug and alcohol use, Tsui argues that "the harm reduction approach can be used for all kinds of addictive behaviour" including gambling and pornography addiction (Tsui, 2000, p.244). However, I would argue that harm reduction is not only useful with behaviour that is "addictive", and therefore can also play a key role in programs which aim to prevent the spread of sexually transmitted infections. For example, if someone regularly has unprotected sex with multiple concurrent partners, that person is not necessarily "addicted" to engaging in unprotected sex, but rather participating in a non-addictive high-risk behaviour. Harm reduction would encourage that individual not necessarily to abstain from having sex with multiple partners, but to use protection more frequently. A harm reduction continuum for this example might look like this:

Figure 2.3 Harm reduction continuum of behaviour representing unprotected sex

Again, the goal of the harm reduction approach is to have the individual's behaviour continue to move towards the left-side of the continuum.

However, despite its wide acceptance, the harm reduction approach remains a controversial and contentious issue. Within the field of substance and drug use, Brown and Horowitz highlight that the harm reduction approach creates the challenge of "how to refocus the field toward minimizing the consequences of alcohol and drug use without condoning use" (Brown & Horowitz, 1993, p.549). The fear that teaching people how to reduce the risk of a behaviour somehow equates to endorsing that behaviour is not limited to substance and alcohol prevention alone. This is also a common objection to sharing information about sexual health, particularly with adolescents. As Lisa Marr, author of *Sexually transmitted diseases: A physician tells you what you need to know* points out, "some people have claimed that if we teach people, especially young people, about sex and how to prevent STDs, then they will become more sexually active" (Marr, 2007, p.90). However, Marr refutes that "nothing is further from the truth" and describes that "studies have shown that the level of sexual activity among young people who are provided with sexual education either stays the same or decreases" while "the degree of condom use and reliance on other safer sex practices increases among young people who are already sexually active" (Marr, 2007, p.90). Marr's sentiments are echoed in *The purity myth* which incorporates a poignant quote from Bill Maher, comedian and social commentator, to summarize the misinformation that access to sexual education is equivalent to endorsing sexual behaviour. Valenti writes "I rarely quote Bill Maher, but he was right on when he noted" that arguing that sexual education promotes promiscuity "'is like saying if you give a kid a tetanus shot, she'll want to jab rusty nails in her feet'" (Valenti, 2008, p. 71).

2.1.3 The role of environment in prevention.

Even as the idea of prevention was beginning to take root in the early 1960's, Caplan identified that "prevention is a community problem and not an individual matter" (Caplan, 1963, p.1556). An individual's environment and context can play just as large of a role in his risk for a condition as sex, gender, or ethnicity. The fields of prevention in mental health and substance use have undergone "an expansion of prevention and research that goes beyond the individual to include the environment in which youth lives: the community" (Brown & Horowitz, 1993, p.542; Caplan, 1963, p.1556). Although not listed explicitly by Brown and Horowitz, the role of environment is also an important consideration in STI prevention.

However, while it has been acknowledged for many years that prevention efforts must consider the role of an individual's community and environment, a fuller recognition of this concept has only began to take hold in recent years. This has been tied largely to the increasing popularity of the harm reduction approach, and an increased focus on an individual's behavioural continuum and personalized risk factors, such as environment. In fact, multiple studies cited by Rotheram-Borus et al. have shown that

> Most heterosexual, HIV-positive youth acquire HIV primarily because of geography; they live in an urban inner city with a high neighourhood seroprevalence rate, typically resulting from high rates of drug use and drug dealing. Within this context, the probability of heterosexual transmission has been associated with more frequent intercourse, less consistent use of condoms,

> multiple sex partners within relatively short time periods, and the presence of a co-occurring sexually transmitted disease. (2000, p.17)

Using this logic, a 15 year-old Caucasian female living in a downtown community of Winnipeg, such as the North End, would require different preventive measures than a 15 year-old Caucasian female living in an affluent suburban area, such as Island Lakes. The populations might be parallel in regards to age, ethnicity, and gender – but environment, and the implications of the environment, becomes an essential consideration.

Yet, as Brown and Horowitz point out, this emphasis on an individual's environment is only important if it challenges the idea of a "deviant population"; a notion that is still prevalent in many prevention initiatives. They describe that this change from the view of the individual to the view of the individual placed within his or her environment does not necessarily represent a significant shift in the field of prevention, and specify that prevention "progress is limited by the unchanging assumption that researchers and programmers hold of a deviant target population" (Brown & Horowitz, 1993, p.533). Without a fundamental change in this underlying belief, considering environment in prevention initiatives is just paying lip service to factors that may heighten an individual's risk for a condition.

A larger focus on the environment has also influenced the development of "protective factors" as an increasingly well-used element of prevention. Protective factors are "influences that modify, ameliorate, or alter a person's response to some environmental hazard that predisposes them to a maladaptive outcome" (Brown & Horowitz, 1993, p.546). Protective factors are commonly interpreted as the opposite of

risk factors, but this is not the case. "Rather, they represent a separate group of factors, defined independently of risk factor research" (Brown & Horowitz, 1993, p.546). The table below illustrates examples of risk factors, and how protective factors in similar circumstances are different than the "opposite" of risk factors:

Table 2.4 *Examples of Risk and Protective Factors*

Risk Factor	"Opposite" of risk factor	Protective Factor
Sharing needles for injection drug use	Not using injection drugs	Using your own needle to inject drugs
Engaging in sexual activity without protection	Not engaging in sexual activity	Using condoms when engaging in sexual activity

An emphasis on protective factors, rather than risk factors, is a practice that seeks to lessen the idea of a "deviant" target population, particularly in regards to prevention initiatives aimed at youth. Brown and Horowitz describe that "protective factor research, with its positive view of the individual…promotes the well-being of all as opposed to the maladaptive identification of adolescents" (Brown & Horowitz, 1993, p. 547).

An additional consideration when comparing the merits of protective factors versus risk factors is that many risk factors are so general that they become meaningless. A common question for STI risk assessment is: How often do you use condoms during sexual activity? Normative possible responses are: Always, usually, sometimes, not often, never. I have often wondered who could qualify in the "always" category. Is there a difference between an individual who does not "always" use a condom with non-committed partners (such as one-night stands), and an individual who does not "always" use a condom with her committed partner? What about a monogamous couple who both

tested negatively for STI before engaging in unprotected sex with each other? This would seem to be a risk free situation that would not necessitate the continued use of condoms. I would estimate that there are very, very few sexually active people who could classify themselves as "always" using a condom. On an STI risk assessment, the absence of many people selecting the response "always use a condom" may lead researchers to conclude that these people are engaging in unprotected sex and therefore at risk for contracting an STI. However, as in the example of the monogamous couple who tested negatively for STI before engaging in unprotected sex with each other, unprotected sex should not always be equated with high risk sex.

Risk assessments, such as the previous example, are limited in their usefulness because they often do not account for the context of the question. In their article, Brown and Horowitz refer to a program that offers many criteria for identifying youth at risk for substance and alcohol use. However, there are so many risk factors, and many are so general (such as "friends who use drugs" and "lack of student involvement"), that it begs the question:

> At what time in his or her life has any adolescent not experienced at least one of these factors? Risk factors are so broadly defined…[any] student under almost any circumstance could be classified as at risk for alcohol or drug use. (Brown & Horowitz, 1993, p.539)

Instead of seeking to identify certain populations as "at risk", a greater emphasis on protective factors seeks to promote practices that individuals *should* be doing based on the behaviours they engage in, instead of listing activities they should avoid.

Brown and Horowitz also caution the importance of differentiating variables that are correlational from variables which are causal when developing prevention initiatives. As they outline in their paper, "risk factors, per se, are unclear and inconclusive as to what they actually predict" (Brown & Horowitz, 1993, p. 535). For example, regarding STI prevention, it is widely accepted throughout the literature that street-involved youth have an increased vulnerability and susceptibility to STI transmission. Brown and Horowitz would argue that it would be inaccurate to state that being street-involved is a risk which *causes* elevated risk of STI transmission. Instead, they would argue that street-involved individuals might display higher rates of STI than the general population, and identify that, while there is a correlation, the relationship between being street-involved and higher rates of STI is not causal. Brown and Horowitz refer to these "maladaptive correlates of risk factors", and "correlation-based assumptions" as Risk Factor Mythology (Brown & Horowitz, 1993, p.535).

2.1.4 The challenge and necessity of evaluation.

When it comes to the field of prevention, lack of evaluative research is a "problem which continues to plague the field" (Brown & Horowitz, 1993, p.532). Moreover, even when prevention efforts are evaluated, the significance and meaning of those measurements can be open to interpretation. Take for example the country of Uganda, heralded by some as a great success in the field of AIDS prevention. Uganda boasted a substantial reduction in the country's adult population with HIV, decreasing from "18 percent in 1995 to around 5 percent at the end of 2001" (D'adesky, 2004, p.142). Ugandan government officials attributed this decline to the efficiency of "the

Ugandan prevention model…that stresses sexual abstinence and monogamy" (D'adesky, 2004, p.142). However, is this the only explanation that might account for this remarkable decline? D'adesky wonders if Uganda's "epidemiological picture somehow reflected the enormous cumulative death toll and a kind of saturation point for the spread of the virus" (D'adesky, 2004, 142). While some credit effective prevention programs, others hypothesize that it was not the prevention initiatives, but instead the vast numbers of people with AIDS who died which mitigated the national number of adult HIV cases.

In addition to other factors potentially influencing the results of prevention evaluation, a second criticism of prevention evaluation arises "when the implicit goal of research is to prove previously held assumptions" (Brown & Horowitz, 1993, p.550). Often, prevention initiatives are based on inconsistent means, such as grants and funding proposals. If the goal of evaluating a program is to justify its existence, or to continue to secure funds, the objectivity of the research may be biased towards portraying the prevention initiative in a positive light.

William Hansen and Linda Dusenbury of Tanglewood Research express that the topic of program continuity is part of the "big picture" of prevention. In their article "Building capacity for prevention's next generation*"* (2001), they identify that "prevention researchers have often limited their focus to thinking about 'the program'. To bring prevention to scale, there will need to be equal effort given to developing a system that supports and sustains it" (Hansen & Dusenbury, 2001, p.208). An evaluation might determine that a prevention program has an excellent success rate, but if there are no means to continue to implement the program, clearly, the impact of the program will be compromised.

In addition to the concern of a biased evaluation, the lack of standardized criteria for measuring the success of a program is also a challenge. This raises the issue that "practitioners who are now required to evaluate programs need clear standards for designing evaluations and for interpreting results" (Hansen & Dusenbury, 2001, p.207). Hansen and Dusenbury propose that the Society for Prevention Research, a multidisciplinary organization, "should be at the forefront in establishing universal standards for evaluation" (Hansen & Dusenbury, 2001, p.207). Without these clear standards, there is often ambiguity and a diverse scope of what elements of a prevention program are being measured. I have seen firsthand that individuals who participate in an HIV/AIDS prevention program are able to easily complete the program's knowledge-based post test with ease. But is being able to list the methods of disease transmission and reciting safer sex practices sufficient to indicate success of a program? It is relatively easy to evaluate whether or not individuals learned anything from a prevention program. It is much more difficult to evaluate if that knowledge has informed the decision-making process or behaviour of the participants.

Tsui describes that one of the benefits of the harm reduction approach is that it can help to facilitate evaluation because there is a scale of measurable short-term operational goals, and therefore, it is easier for the researchers to evaluate its effectiveness (Tsui, 2000, p.245). However, the ease of measuring these short-term goals may be more feasible with a drug or alcohol prevention program. Blood and urine tests can objectively identify the amount of a substance an individual has been using (or abstaining from using). This amount can be compared to tests of previous drug and alcohol amounts to evaluate the effectiveness of the intervention. One of the significant

challenges in evaluating the effect of STI prevention programs is that data collection relies largely on self-disclosure of participants. While there are different types of tests which can identify if an individual already has an STI, there are no tests to determine if an individual is using a condom, or tests to identify in which types of behaviours an individual is engaging. In certain communities, individuals may be unwilling to share their behaviour candidly with a program evaluator – particularly if they know what the desired responses should be and fear negative judgment.

Despite the challenges of evaluation, knowledge of the strategies and initiatives which are most effective in preventing various conditions is absolutely essential to ensure that funds and energy are directed towards programs which achieve results. As O'Connell et al. explain, the results of effective prevention programs can have real and tangible benefits for society as a whole:

> The proverbial ounce of prevention will indeed be worth a pound of cure: effectively applying evidence-based prevention interventions…could potentially save billions of dollars in associated costs by avoiding or tempering these disorders in many individuals. Furthermore, devoting significantly greater resources to research on even more effective prevention and promotion efforts, and then reliably implementing the findings of such research, could substantially diminish the human and economic toll. (O'Connell et al., 2009, p.14)

The integral idea of prevention lies in the concluding sentence. While quality prevention makes economic sense, the heart of prevention seeks to avoid suffering and

affliction for the people who are affected by the conditions that these programs seek to prevent.

Human behaviour can be a challenging thing. It is challenging to predict; challenging to understand; and especially challenging to change. I recently overheard a man expressing that he did not understand why new cases of HIV were still occurring. According to his logic, we already know the methods of transmission – so why don't people just stop doing the things that put them at risk for infection? Consider all of the health challenges that could be avoided if people changed their behaviour based on knowing what was "good" for them. No one would smoke cigarettes. No one would eat fast food. Everyone would exercise regularly. Prevention is more complicated than dispensing information and expecting people to adapt their behaviour accordingly. There are contexts to consider; an individual's environment, culture, social norms, gender, sexuality, ethnicity, prior knowledge of the issue, education level, socioeconomic status, and the list goes on. All of these factors might influence the type of preventive measures best suited to that individual.

It would be erroneous to imply that all behaviour is a choice. Women who are forcibly involved in the sex trade have no control over their patrons' use of condoms, in spite of how much information they may have received about condoms reducing the risk of STI. But, regardless of there being a behavioural change, individuals have a right to access accurate information about their behaviours and their bodies. Knowledge is power. For many, power means the ability to choose. And when the conditions and context are right, the behaviours people choose might just inch them towards the left-hand side of the harm reduction continuum.

2.2 Street-Involved Youth

"Brokenhearted"

At times I feel broken hearted;
I feel all alone,
In a place to (*sic*) big,
I have no real friends,
I have no real family,
I sit here sad and alone,
Cold and half numb,
Without the resources to finish me off,
I guess that's my destiny,
To go on,
Sad and alone,
All on my own,
Broken hearted.

- Anonymous submission to *Harsh Reality*

2.2.1 What does "street-involved" mean?

They are the young people squeegying windshields at the corner of Broadway and Colony Street. They are the people busking in Osborne Village. They are the people with the big backpacks and a few dogs in tow trying to find warmth in bus shelters during winter. They are the street-involved kids, the homeless kids, and they exist in every city and every country in the world.

However, while key characteristics of street-involved youth can often be found throughout existing literature, it is rare to find two identical definitions of street-involved youth. In many cases, the terms "street-involved youth" and "homeless youth" are used interchangeably. This paper will largely employ the term "street-involved" due to the misconception that the term "homeless" applies only to those who live and sleep outside "in the street".

In fact, the terms "street-involved" and "homeless" encompass more than individuals who sleep outside on the street. Individuals who access the services of shelters, including spending the night at shelters, are also included in the "homeless" category (Zerger, Strehlow, & Gundlapalli, 2008; Haldenby, Berman & Forchuk, 2007; Taylor-Seehafer et al., 2007). In addition, the term "homeless" includes youth who are "doubling up" such as staying with friends (Zerger et al., 2008, p.825), or staying with lovers (Ensign & Santelli, 1997, p.817). It is common for youth who are categorized as "homeless" to be "continuously moving between temporary housing arrangements" (Haldenby et al., 2007, p.1232) and to "lack a fixed, regular and adequate nighttime residence" (Taylor-Seehafer et al., 2007, p.38). This chronic transience is often referred to as "couch surfing" (Haldenby et al., 2007) because youth are rotating, or "surfing", from couch to couch in different locations.

Individuals who are "homeless" in the traditional sense of the word face the challenge of having to find creative locations where they might spend the night. This may include "sleeping in parks, stairwells, or abandoned cars" (Haldenby et al., 2007, p.1237) or "camping out on the street and in public places" (Zerger et al., 2008, p.835) such as bus shelters and parkades. Some researchers have also included youth who live in "substandard housing" (Zerger et al., 2008, p.826) and "unstable residences" (Taylor-Seehafer et al., 2007, p.38) as part of their definition of homelessness.

Researchers have different ideas about to what extent the term "homeless" includes systems-based youth, such as youth in the foster care system or in correctional facilities. Zerger et al. caution that youth being released "from the foster care or corrections system after aging out at 18" are two of the most common means by which

youth become homeless (2008, p.835), but stipulate that term "homelessness typically encompasses only those actively using services such as shelters and health clinics" (Zerger et al., 2008, p.826). Haldenby et al. also do not include systems-based youth under the umbrella of homelessness (2007).

Conversely, Taylor-Seehafer et al. include youth within "system-based institutions" as part of their definition of homeless youth (2007, p.38). Ensign & Santelli (1997) developed four widely-referenced categories for classifying homeless or street-involved youth, one of which pertains exclusively to systems-based youth. The following table summarizes their classifications:

Table 2.5 *Ensign & Santelli's Four Categories of Street-Involved Youth*

Runaways	Throwaways	Street Youth	Systems Youth
Youth who left home voluntarily	Youth who left home involuntarily	Youth doubling-up with friends or lovers	Youth involved in institutional or foster care system

(Based on Ensign & Santelli, 1997, p.817).

While this system of classification is helpful, it is not without its shortcomings. For example, how would an individual who ran away from home and is now living in a shelter be categorized: as a "runaway" or "systems youth"? Despite potential limitations, Ensign and Santelli's classifications begin to address the often complex and compelling reasons that drive youth to become street-involved.

2.2.2 Who becomes homeless?

There are a variety of factors which may precipitate or increase one's risk for becoming homeless. For instance, young people are significantly more susceptible to becoming homeless than adults. Zerger et al. attribute this to youth being

> Less likely than older adults to have resources in place to prevent homelessness or to cope should it occur…They are more likely to have low-paying jobs with few benefits and are less likely to have health insurance, substantial savings, or experience with housing matters, legal rights, or community resources. (2008, pg 825)

In addition to lack of life experience compared to adults in similar situations, one of the most cited factors that precedes youth becoming street-involved is their family context. This might include "a family without the means or desire to support them" (Zerger et al., 2008, p.825), "being kicked out of home by disapproving parents" or "escaping an abusive parent" (Zerger et al., 2008, p.835). The avoidance of abuse is a recurring theme in existing literature; Haldenby and colleagues describe "various forms of abuse, including physical, sexual or emotional, as main factors that can cause young people to flee their homes" (Haldenby et al., 2007, p.1233). Despite the hardship of life on the streets, for youth experiencing familial abuse, these hardships may be preferable to the environment they endure at home.

Haldenby et al. reference a study, conducted by the city of Toronto in 1999, that concluded "there is a widely accepted misconception that youth who reside on the streets are there by choice" (Haldenby, 2007, p. 1233). However, while the majority of youth who are street-involved are most likely there due to a combination of circumstances, it

may be an oversight to state that *no* youth are on the street because they choose to be. "The street" offers a lifestyle which may appeal to some. It is non-conformist. It is exciting. At times, it can be dangerous. In short: it can be just the form of escapism some people are looking for. While not the majority, some of the youth who are spending time on the street may be involved in street life and street culture while maintaining a consistent place of residence.

The examples of the differing reasons why youth may become homeless serve to illustrate that there is not just "one type of person" who becomes street-involved. Haldenby et al. point out that, in the past, "many researchers have tended to characterize this population as a homogenous group. In effect, this depiction negates the importance of gender, race, ability, or other social locations and identities" (2007, p. 1234). Zerger and colleagues echo this sentiment, and describe that currently "researchers are beginning to develop a more sophisticated understanding of issues facing this non-homogenous group" (2008, p.827). One of the most evident ways to identify that street-involved youth are not homogenous is by identifying demographic characteristics, which generally reflect those of the local community (Ensign & Santelli, 1997, p.817).

However, when examining the characteristics of individuals who are street-involved, there can often be subgroups within subgroups. Take, for example, the distinction between street-involved youth who use substances and street-involved youth who do not (sometimes referred to as "straight edge"); even within these subgroups, the populations are not homogenous. There are considerable differences in lifestyle and social perception between users of different substances. In Winnipeg, solvent users are generally perceived in very low regard by other substance users. This may be due, at

least in part, to the lower cost of obtaining solvents to use as opposed to substances which are more expensive and therefore more exclusive.

One of the subgroups gaining increased attention for their heightened vulnerability are street-involved youth who are gay, lesbian, bi-sexual, transgender or questioning (GLBTQ. In some literature this acronym includes an additional T to represent individuals who are two-spirited: GLBTTQ). This subgroup is "overrepresented among homeless youth; precisely to what extent we do not know" (Zerger et al., 2008, p. 832). Further, "homeless youth who self-identify as GLBTQ exhibit greater risk and negative outcomes than those who are heterosexual" (Zerger et al., 2008, p.832). To these points, I would add that youth who do not self-identify as GLBTQ but are perceived to be GLBTQ are also at heightened vulnerability. For example, many males who work in the sex trade and engage in sexual acts with men are actually heterosexual, but "work as a gay young person to earn money" (McIntyre, 2007, p.58). These males, referred to as "gay for pay", are just as vulnerable to gay bashing and harassment as their fellow sex-trade workers who may be homosexual.

Due to disapproval over their sexuality, many street-involved youth who are GLBTQ could be classified by Ensign & Santelli as "throwaways" or "runaways" who left home due to conflict with their parents or guardians (Rew, Whittaker, Taylor-Seehafer, & Smith, 2005, p.11). In addition to facing possible judgment and persecution from their families, the stigma associated with being gay may drive "youth to seek romantic partners and services outside of their local school and community" (Rotheram-Borus et al., 2000, p.17).

There is evidence that suicidal ideation is prevalent among street-involved youth as a whole, but "this risk is amplified among gay, lesbian, bisexual, and transgender youth" (Haldenby et al., 2007, p.1233). In addition, "this subgroup is more likely to have early onset of sexual experience, involvement in prostitution or survival sex, multiple sex partners, and other sexually risky behaviours" (Zerger et al., 2008, p.832).

While the risks associated with identifying as or being perceived as a GLBTQ street-involved youth are clear, "what is not clear is whether and to what extent the risks precede their homelessness" (Zerger et al., 2008, p.832). The answer to "which came first?" is often a complex question to answer. In many cases, participation in high risk behaviours may serve to further entrench the individual in a street-involved lifestyle, and entrenchment in a street-involved lifestyle may facilitate participation in more high risk behaviours.

Whereas one's sexuality may not be overtly observable, one attribute which is often visibly identifiable is an individual's gender. Gender is also a key characteristic which may greatly influence a street-involved youth's experience. To this end, the subgroup of street-involved women and girls is particularly vulnerable. Haldenby et al. go so far as to state that "the unique challenges faced by homeless female adolescents" render them "the most vulnerable subculture within the homeless population" (2007, p.1234). Female street-involved youth and women have expressed that they are more susceptible to violence and exploitation on the street, including being "significantly more likely to be sexually assaulted than men and boys" (Haldenby et al., 2007, p. 1234).

On top of fundamental considerations such as food and shelter, there are additional financial considerations which are necessary for females; such as funds "needed for feminine hygiene products and birth control" (Haldenby et al., 2007, p.1239). Zerger et al. point out that many "homeless young adults are also raising children of their own" (2008, p.825) and, in many cases, this parenting responsibility lies primarily with the mother.

The acknowledgement of different subgroups under the umbrella of street-involved youth is an important step in developing an understanding of their daily context. Just as there is not one type of individual who becomes street-involved, the resources and supports required to survive on the street may be markedly different for individuals with differing characteristics. These differences can impact a youth's safety, vulnerability, and personal experience. More importantly, these differences can impact the ability of a street-involved youth to continue to exist in an often unpredictable and unsafe environment.

2.2.3 Survival on the street.

Although Canada is, by world standards, an affluent and first-world country, it is not uncommon to hear the word "survival". University students might refer to "surviving first year Medicine"; colleagues might breathe a sigh of relief after "surviving fiscal year end at work". But, when street-involved youth talk about survival, it is not a hyperbole or a euphemism for "busy period". Survival is just that: not dying; scraping your way through another day, another week, maybe another hour. Survival on the street is not limited only to finding a place to spend the night. Fundamental considerations such as food, bathrooms and hygiene, and basic personal safety must be addressed on an

ongoing basis. Haldenby and colleagues describe that "living on the streets often forces adolescents to focus on daily survival" (2007, p.1241). They continue to describe that for the street-involved youth who participated in their study,

> Being exposed to constant threats of violence with no safe place to go, the youth's daily focus was on meeting their urgent safety and physical needs…The fact that they were living on the streets and still alive was something they were proud of. (Haldenby et al., 2007, pg. 1238)

For these youth, survival itself is the most important accomplishment.

A welcome distraction from the ongoing struggle of survival on the street can be found in the escape of drugs, alcohol, or other substances. There is a strong connection between street-involvement and substance use. "Several small and large scale studies have found 70% to 97% of homeless youth abuse alcohol, illicit drugs, or both and noted that risk increases with age and duration of homelessness" (Zerger et al., 2008, p. 833). Funds are required for individuals to purchase substances they use and, in some cases, are addicted to. For some street-involved youth, the desire to procure these substances may supercede other basic necessities for survival.

Just as there are multiple reasons why youth may become street-involved, there are multiple reasons why individuals may begin to use substances. One of the primary driving forces is mental health problems, which "are not uncommon among homeless youth and frequently occur in combination with one or more substance use disorders" (Zerger et al., 2008, p. 833). While some mental health disorders may have been pre-existing (such as depression), some mental health disorders, such as post-traumatic stress disorder (PTSD), may have been incurred as a result of abuse incurred before the youth

became street-involved. In particular, "a history of childhood sexual abuse increases the risk of substance abuse among homeless youth" (Haldenby et al., 2007, p. 1234). In addition to substance use, self-harm practices such as cutting and burning, may also be employed to deal with mental health disorders.

While in some cases substance use may be to deal with the mental and psychological aspects of life, substance use can also mitigate physical effects of life on the street. Sacol, a glue commonly used to repair shoes in Colombia, is frequently used as an inhalant by street-involved youth in the city of Medellín. Sacol's popularity is based largely on its affordability and its ability to diminish feelings of cold and hunger for the user. In Winnipeg, solvent users may switch from their usual solvent of choice (such as glue) to inhaling wood lacquer in the winter months. Similar to Sacol, inhaling wood lacquer diminishes feelings of cold in the user (more so than other solvents).

However, although the use of substances may help to deal with the adverse environment of the street, use of substances also impedes youth's ability to access services; access to shelters in Winnipeg provide one such example. While there are multiple shelters for the street-involved population in Winnipeg, only one, Main Street Project, allows patrons to access services while under the influence of drugs, alcohol or other substances. Therefore, in winter months, an individual inhaling wood lacquer to diminish feelings of cold would be ineligible to stay in the majority of Winnipeg shelters. This could result in the individual having to spend more time outside in the cold, which would require finding a strategy to stave off the cold, such as inhaling more wood lacquer. For individuals who use substances in order to deal with the elements, this becomes a difficult cycle to break.

In addition to mitigating physical challenges such as hunger and cold, substance use can also serve to numb the mind or body to activities that are harmful or painful. Haldenby et al. describe that "there are reports that a relationship between substance abuse and prostitution among homeless female adolescents exists, which is thought to have adverse consequences for the women's physical and emotional health" (2007, p.1234). This relationship between substance use and the sex trade is not limited to females alone. Between 2005 and 2008, Dr. Sue McIntyre conducted a study, *Under the radar,* throughout Western Canada in order to gain a better understanding of males involved in the sex trade. In the Manitoba phase of the study, the majority of the 40 participants expressed negative feelings towards working in the sex trade; 20% reported "hating" how they felt, 13% felt "nervous", and 34% felt "dirty" (McIntyre, 2007, p.43).

McIntyre describes that these males involved in the sex trade feel exposed to the public and also, in many cases, must grapple with unpleasant feelings and inner turmoil about the work they are involved in. Therefore, these males numb themselves, psychologically and physically, "to deal with the shame they feel. Substances such as alcohol and drugs help them achieve this sensation of numbness" (McIntyre, 2007, p.43). Substance use is prevalent among street-involved youth in general, but this prevalence is even more elevated among those involved in the sex trade.

Survival sex, the exchange of sex acts for money or in order to meet needs, is a reality for many street-involved youth. In *Under the radar*, McIntyre describes that none of the participants had the goal of entering the sex trade. Instead, "over 75% saw this activity as a short-term method to make money so they could survive" (McIntyre, 2007,

p.36). However, once one becomes involved in the exchange of sex acts for money or basic needs, it can become very difficult to extricate oneself from that lifestyle.

Often, individuals initially become involved in the sex-trade because they are new to life on the street and are attempting to meet their urgent needs, such as food and shelter. In Haldenby and colleagues' study, the adolescent participants "shared that women are more likely to sell their bodies as a means to meet their various needs, one of which was a place to sleep" (Haldenby et al., 2007, p.1239). *Under the radar* highlights that this phenomena also occurs with street-involved males, particularly when the males are new to the street or have recently run away. Of the 40 participants, "eighty-one percent of those who had run away were offered food and/or shelter: however, for 73% there were conditions attached to this offer. Most of these conditions were sexual in nature, representing an introduction and entrance into the sexual exploitation trade" (McIntyre, 2007, p.37).

There may be a public misconception that youth being sexually exploited through the sex trade, and specifically youth who are exploited through survival sex, are problems that take place only in very large Canadian cities such as Vancouver and Toronto. Unfortunately, this is not the case, and survival sex is a reality in cites of all sizes throughout Canada. Child Find Manitoba, a provincial agency under the auspice of the national non-profit organization the Canadian Centre for Child Protection, launched a multi-phased campaign, in partnership with the government of Manitoba, to bring awareness to the reality of survival sex in Winnipeg. In 2008, through posters, billboards and public service announcements, the *Stop Sex with Kids* campaign attempted to draw attention to the often closeted issue of survival sex for both male and female street-

involved youth. Campaign posters were displayed on billboards and on bus stops with photos of youth and captions reading "Dear diary, I needed a place to stay. I didn't know it would be that bad. I feel worthless" and "Dear diary, last night I was so hungry. That guy did what he wanted with me…I needed to eat" (Child Find Manitoba, 2008, Campaign/phase II/posters). Despite the public awareness campaign, the exchange of sexual favors for money, drugs, or basic needs continues to be a means of survival for street-involved youth in Winnipeg.

Notwithstanding the lack of attention that the issue of sexual exploitation often receives, every so often, an issue will arise that brings the topic of the sex trade to the forefront of national consciousness. Such was the case in 2007 when Robert Pickton was tried for the murder of 27 sex trade workers in Vancouver, British Colombia. Pickton's trial provided the opportunity for Canadian society to acknowledge the vulnerability and danger inherent for those who are involved in the sex trade.

Based on the data obtained from the Canadian studies *Strolling away* (2002) and *Under the radar* (2007), McIntyre concludes "both males and females in the sexual exploitation trade fear violence while working" (McIntyre, 2007, p.49). However, the type of violence that males and females involved in the sex trade are susceptible to differs. For females, "the main source of violence emanates from customers seeking their services. For males, the main source of violence is the result…of gay bashing from onlookers who suffer from homophobia" (McIntyre, 2007, p.49). Strategies for staying safe while working in the sex trade include carrying weapons, not staying too long in one location, standing in well-lit locations, standing with friends, and relying on one's

intuition and gut feelings about a customer, commonly referred to as a "John" (McIntyre, 2007, p.55).

Many of these safety strategies are also employed by street-involved youth who are not involved in the sex trade. In the Ontario study done by Haldenby et al., the participants told about creative strategies they used in an attempt to feel safe. These included being part of a group, which served as a form of protection while sleeping outside, and also served as protection during the day as "back-up" in the event of a fight or altercation (2007, p.1238). Additionally, participants described that the safety strategy of carrying a weapon to defend oneself was a normative practice (2007, p.1238).

But perhaps the most relied-upon protective strategy of all is the ability for street-involved youth to discern who can be trusted. The acquired knowledge of who can be trusted, and reliance on one's own intuition, may be largely related to the duration of homelessness. Zerger et al. explain that for many street-involved youth, "homelessness is an episodic, not a chronic, experience" (2008, p.835). There may be a marked difference between someone who has experienced multiple episodes of homelessness as opposed to a youth who is facing life on the streets for the first time. To someone new to life on the street, finding available resources such as shelters, food banks, and public bathrooms, in addition to learning to determine who can be trusted and who has ulterior motives can be an overwhelming experience.

However, as a youth acquires more episodes of life on the street, more experience can translate into a more developed sense of intuition about people and situations to avoid. In addition to gaining personal experience, a heightened awareness of, and reliance on, one's intuition can be modeled and taught by peers (McIntyre, 2007,

p.54). Increased reliance on intuition can, in turn, translate into increased likelihood of survival. For example, 50% of the sex trade workers in *Under the radar* had "refused a customer because of a bad feeling they got; an uncomfortable 'vibe'" (McIntyre, 2007, p.54). Avoiding situations which trigger uncomfortable feelings may be the difference between accepting a treacherous "John" like Robert Pickton, and making it through another day. Necessities such as food and shelter considered, it is the ability to trust your gut that is the best tool for surviving life on the street.

2.3 Homelessness, Health and HIV

2.3.1 Homelessness, health, and HIV: Rates of STI.

"When people are placed in circumstances in which they cannot maintain stable relationships, life is risky and pleasures are few and necessarily cheap, then sexually transmitted diseases will be rampant."

- Alan Whiteside

It should come as no surprise that the ongoing struggle to meet basic needs and the resulting inconsistent access to shelter, food, sleep, and safety have an adverse effect on street-involved youth's health and well-being. Life on the street has many implications for the overall mental and physical health of street-involved youth; from the physical effects of compromised nutrition and substance use, to mental challenges such as high rates of self-injurious behaviours and suicidal ideation (Zerger et al., 2008, p.834). Research has also shown that "poor health outcomes in homeless youth…multiply in number as the duration of homelessness lengthens" (Rew et al.,

2005, p.11). While describing all of the potential health risks associated with life on the street is beyond the scope of this paper, a topic of particular significance is the relationship between street-involvement and the prevalence of sexually transmitted infections, and specifically the prevalence of HIV.

In 2004, the results from the *Enhanced surveillance of sexually transmitted diseases among Winnipeg street-involved youth study* were made available through Manitoba Health. The study, overseen by Dr. Carole Beaudoin, gathered data from interviews with 320 street-involved youth in Winnipeg. The interviews aimed to collect information "to better understand the incidence of STI among street youth and the behavioural and social risk factors that place them at risk for infection" (Manitoba Health, 2004, p.ii). The study was undertaken with the contextual knowledge that, all across Canada, "the rates of both chlamydial and gonococcal infections have been increasing across the country since the late 1990's" (Health Canada, 2003). This is of particular concern in Manitoba which, in 2003, had the second highest chlamydia rate and the highest gonorrhea rate in the country (Health Canada, 2003). Beaudoin describes that both nationally and in Manitoba, the overall rates of STI are influenced by very high rates in certain vulnerable segments of the population, such as in First Nations people (Manitoba Health, 2004, p.3; Whiteside, 2008, p.12) and among street-involved youth (Manitoba Health, 2004, p.3).

Physician Lisa Marr argues that, in general, adolescents are more suceptible to the transmission of STI. This is consistent with cases of chlamydia and gonorrhea in Manitoba; the majority of cases occuring among 15–24 year olds (Manitoba Health, 2010, p.5). Marr acknowledges that "although anyone, of any age, can become infected

with an STI, teenagers are particularly vulnerable because of lack of information" (Marr, 2007, p.82). In addition to adolescents' heightened vulnerability due to lack of information, Rotheram-Borus and colleagues draw from various studies to assert that a number of physical characteristics present in adolescent females further increase this subgroup's vulnerability. In particular, Rotheram-Borus et al. note that "the columnar epithelium of the cervix is more exposed during adolescence than adulthood and is a primary site for chlamydia and gonococcal infection" (Rotheram-Borus et al., 2000, p.18). Furthermore, "the immune-protective factors of the cervical mucus do not fully develop until 2 to 3 years after menarche" (the first menstrual cycle) (Rotheram-Borus et al., 2000, p.18). This means that sexually active adolescent females who have not yet menstruated, or are within a few years of their first menstruation, are one of the groups most vulnerable to contracting an STI.

For many adolescents in Manitoba, the information they receive about STI may come from *Physical education/health education: Manitoba curriculum framework of outcomes for active healthy lifestyles* (Manitoba Education and Training, 2000); the provincially mandated curriculum document about sexual health and reproduction. However, often it is not normative for youth who are street-involved to attend school. For street-involved youth, the continuous focus on daily survival makes it difficult to stay enrolled in school (Haldenby et al., 2007, p.1241). This trend was reflected in the *Winnipeg street-involved youth study*, in which "more than half of the street youth sampled (n=176, 55.2%) were not registered for school" (Health Canada, 2004, p.6). While traditional schooling is not the only method wherein youth can learn about sexual

health and STI, for street-involved youth who are not attending school, this decreased access to sexual health information can increase their vulnerability to STI.

In addition to lack of access to school-based information, "out of school youth…are at particularly higher risk for HIV due to their sexual behaviour" (Rotheram-Borus et al., 2000, p.17). Rotheram-Borus et al. cite the statistic that "about 70% of school dropouts are sexually active at an early age (compared to 45% among in-school youth), and many more school dropouts (36.4%) report 4 or more sexual partners than do in-school youth (14%)" (2000, p. 17). The fact that early sexual debut and multiple sexual partners are high risk behaviours associated with school drop-outs, in combination with research that suggests that often street-involved youth do not attend school, further contributes to the elevated vulnerability of the street-involved population for contracting STI and HIV.

In the general population of Canada, "by age 14 or 15, about 13% of Canadian adolescents have had sexual intercourse" (Statistics Canada, 2005, p.11). However, "homeless youth are more apt than their housed peers to be sexually active and to have started having sexual intercourse 2 to 3 years earlier than other adolescents" (Zerger et al., 2008, p.830). The age of sexual debut is of importance because "the sooner that young people start having sex, the longer they are exposed to the risk of…contracting a sexually transmitted infection" (Statistics Canada, 2005, p.9). Furthermore, "the younger a woman begins penetrative sex, the greater her risk of infection due to the danger of tearing of the vagina" (Whiteside, 2008, p.45). This logic may also be applied to males; the earlier a male engages in penetrative sex, the more likely tearing may take place that could facilitate exchange of bodily fluids.

One of the most effective methods to prevent transmission of STI during sex is through the use of condoms. However, multiple studies have documented that condom use is not normative amongst street-involved youth (Zerger et al., 2009: Rotheram-Borus et al., 2000; Ensign & Santelli, 1997; Rew et al., 2002). This no doubt has contributed to the rates of STI infection among homeless youth being "3 to 10 times higher than rates among their housed counterparts" (Zerger et al., 2008, p.830).

The incidence of survival sex among the street-involved population also plays a role in the elevated rates of STI. Haldenby et al. describe that because "homeless adolescents are often forced to engage in 'survival sex'…as a result, these adolescents might have more sexual partners than the adolescent population in general" (2007, p.1233). Additional studies also discuss that street-involved youth's engagement in both the sex trade and unprotected sex are consistently associated with HIV (Zerger et al., 2008; Rew et al., 2002). Compounding the risk of individuals involved in the sex-trade becoming infected with an STI through unprotected sex, these individuals are also at heightened risk for sexual violence, such as rape (Haldenby et al., 2007; Zerger et al., 2008). Any time there is sexual violence, there is an increased chance of ripping or tearing in the victim being assaulted. This, in turn, facilitates a higher risk for transmission of infected body fluids

Existing rates of STI, such as chlamydia, gonorrhea and herpes, can also play a significant role in terms of HIV infection and prevention. Even outside of the street-involved population, STI are becoming increasingly prevalent. For example, in the United States, "by the age of twenty-four, one of every three sexually active people will have a sexually transmitted disease" (Hyde & Forsyth, 2007, p.81). As Whiteside

explains, STI which cause genital ulcers and sores "create a portal for the virus to enter the body, and at the same time the presence of the cells HIV seeks to infect, CD4 cells and macrophages, is increased" (Whiteside, 2008, p.42). Therefore, the ability to recognize the potential symptoms of an STI, and ability to access testing and treatment are valuable assets to prevent the transmission of STI, particularly HIV. In fact, Rotheram-Borus et al. go as far as to declare that prevention, detection, and treatment of adolescent STIs is not only valuable, but essential to HIV prevention in adolescents (2000, p.18)

However, even when street-involved youth are able to recognize the symptoms of an STI, they may be unaware of the importance of seeking medical attention. A study undertaken by Rew, Chambers and Kulkarni (2002) from the University of Texas concluded that "homeless adolescents had knowledge about symptoms, transmission, prevention and treatment of STI but lacked understanding of the longer term sequelae of untreated STI" (p.168). Treatment of STI is an imperative factor in the prevention of HIV.

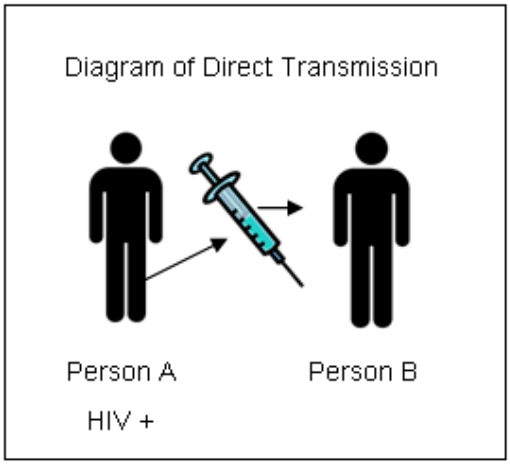
2.3.2 Homelessness, health, and HIV: Substance use and transmission.

An additional factor which places street-involved youth at heightened risk for contracting HIV is the elevated rate of substance use. Substance use is a unique risk factor because "substance use has both a direct and indirect role in HIV transmission among adolescents. Needle sharing is a direct risk for HIV transmission" (Rotheram-Borus et al., 2000, p.18) because it involves skin piercing instruments which facilitate

contact with infected blood. In the United States, for example, injecting drugs accounts for 7% of the cases of seropositive youth (Rotheram-Borus et al, 2000, p.16).

The following diagram depicts an example of direct HIV transmission as a result of substance use.

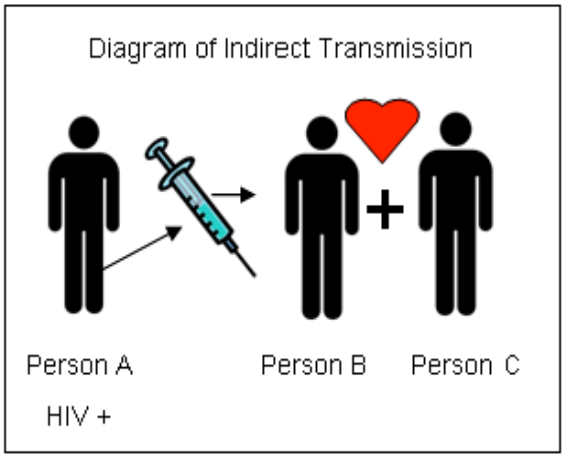
Figure 2.4 Pictorial depiction of direct HIV transmission



In this example, Person A uses a needle to inject drugs. Person B then uses the same needle to inject drugs. Person B is at risk for direct transmission of HIV because Person B is using a needle which has contacted Person A's HIV + blood.

However, in addition to the direct risk of HIV transmission, substance use can also influence the number of individuals at indirect risk of transmission due to "the number of street-involved youth having unprotected sex with injection drug users (Rotheram-Borus et al., 2000, p.18). The following diagram represents a possible example of indirect HIV transmission related to substance use:

Figure 2.5 Pictorial depiction of indirect HIV transmission



Again, in this example, Person A uses a needle to inject drugs, then Person B uses the same needle to inject drugs. Person B has unprotected sex with Person C. Person C is at risk for indirect transmission of HIV because he comes into contact with Person B's bodily fluids (which may be HIV + due to Person B sharing needles with Person A, who is HIV +).

In addition to youth who are at risk of HIV transmission from using injection drugs, or having sex with injection drug users, substance use in general may contribute towards more frequent participation in activities which facilitate HIV transmission. Even the use of substances that don't require injection, such as inhaling cocaine or smoking crystal meth, can influence a user's risk of HIV transmission. As previously discussed, this is of particular concern with the street-involved population as rates of substance use are significantly higher than the general population. A number of studies have found that "substance use impairs decision making and is indirectly linked with the risk of HIV transmission more often for youth than for adults" (Rotheram-Borus, et al., 2000, p.18). In particular, "adolescent females who use psychoactive substances during sex report

higher numbers of sexual partners and a greater likelihood of having had an STI" (Rotheram-Borus et al., 2000, p.18).

The use of alcohol has also been demonstrated to have a disinhibiting effect on sexual activity. Multiple studies referenced in the *Enhanced surveillance of sexually transmitted diseases among Winnipeg street-involved youth study* have found that "alcohol consumption is frequently associated with risky sexual behaviours, including unprotected sexual activity" (Manitoba Health, 2004, p.14).

In some cases, street-involved youth may be aware of the risks of participating in unprotected sex, and the benefits of seeking treatment for STI. However, even though a street-involved youth may have this knowledge, a number of barriers exist for street-involved youth seeking access to the appropriate health-care services.

2.3.3 Homelessness, health, and HIV: Access to care.

As established in the previous sections, youth who are street-involved are more suceptible to mental and physical health challenges than the general population. "Despite this fact, many researchers have found that these youth are the least likely to access the available health care services" (Haldenby et al., 2007, p.1233). One of the biggest challenges facing the health and well-being of street-involved youth is access to care. Numerous studies have found that there are multiple barriers to street-involved youth accessing health-care services (Haldenby et al., 2007; Rew et al., 2002; Zerger et al., 2008; Rotheram-Borus et al., 2000).

For street-involved youth, one of the primary challenges in accessing medical care is that "clinical services are often not available in settings convenient to

adolescents" (Rotheram-Borus et al., 2000, p.20). "Not convenient" may include factors such as inconvenient location (geographically far, or in a locale that is difficult to access by public transportation) and inconvenient facility hours.

It may also be difficult for street-involved youth to obtain the documentation required to access healthcare services. For example, in Manitoba, a person is ineligible to obtain a Manitoba Health Card, a document required for almost all medical services (including hospitals and walk-in clinics), until she is 18 years old, can provide a fixed address, can prove provincial residency, and can provide several other pieces of identification to substantiate her identity. If a youth is under 18 and has lost his Manitoba Health Card, the replacement card must be applied for by a parent or guardian. Clearly, this poses problems for street-involved youth who have run away and severed ties with their families. While a Manitoba Health Card is free to obtain, the location of where to obtain the card, and the requirements involved in applying for a card, may be unfamiliar and possibly overwhelming to street-involved youth seeking the document.

A further barrier impeding access to care is the cost associated with some medical treatments. For example, participants in the study undertaken by Haldenby et al. pointed out that they are "unable to afford expensive prescriptions or eye exams" (2008, p.1239). These prohibitive costs would likely also extend to dental services that can be very costly for individuals without benefits or insurance.

Furthermore, even if street-involved youth are able to access health services at a convenient location and hour, and have the appropriate documentation, the desire to avoid a potentially negative experience may serve as a deterrent to service access. Youth may not feel comfortable accessing services that, in their opinion, are tailored for

adults. In fact, research has found that "young adults often find facilities designed for adults intimidating and uncomfortable" (Zerger et al., 2008, p.828).

In addition to finding the facility uncomfortable, street-involved youth may find interactions with facility staff unpleasant. Haldenby and colleagues describe that one of the most significant barriers for street-involved youth accessing care is "fears they will experience discriminatory attitudes and be negatively judged by health providers" (Haldenby et al., 2007, p.1234). In their study, participants described that often, when accessing health care, "their concerns were either perceived to be untrue or trivialized" (Haldenby et al., 2007, p. 1238). On the part of the healthcare provider, it may be perceived that the youth does not really value her health and well-being if she participates in behaviours such as survival sex, substance use, or self-harm.

Zerger and colleagues, however, are quick to point out that this perception is not necessarily the case. They describe that "it should not be assumed that unsafe or risky behaviours…negate young adults' interest in knowing more about their health and how to protect it" (Zerger et al., 2008, p.829). As discussed previously in this chapter, human behaviour is not as simple as "when you know better, you do better" (apologies to Maya Angelou who is credited with that well-known quote). Many factors may influence the behaviours undertaken by street-involved youth, including undertaking high-risk activities in exchange for basic amenities (such as survival sex), to deal with painful memories (substance use), and for some, as a form of recreation (substance use or sexual behaviour). In order to mitigate the fear of negative judgment when accessing health services, it is "crucial for health care providers to better understand the health perceptions and experiences of this group in order that more effective approaches to

health care can be provided" (Haldenby et al., 2007, p.1233). This would include providing services at times and locations which are convenient for street-involved youth to access, and facilitating a supportive and non-judgmental environment.

2.4 Limitations in Existing Research about Street-Involved Youth

By far, the most prevalent limitation which is cited in regards to research with street-involved youth is the challenge of access (Ensign & Santelli, 1997; Haldenby et al., 2007; Zerger et al., 2008). This challenge affects research in many ways, from data collection, to member-checking data, to following up on findings.

One of the primary consequences of difficulty accessing street-involved youth is that much of the existing research relies on recruitment of street-involved participants who are using services, such as clinics or shelters. As a result, most existing research speaks to individuals who are "visibly living on the streets, even though…far more are hidden and avoiding services" (Zerger et al., 2008, p.835). Ensign and Santelli point out that homeless youth tend to be even more "hidden" and "difficult to access" than adults who are street-involved (1997, p.817). This may be due to youth's reservations about accessing public services they perceive are targeted towards adults.

Furthermore, the ongoing transience and mobility of street-involved youth contributes to their inaccessibility (Ensign & Santelli, 1997; Haldenby et al., 2007; Zerger et al., 2008). It becomes difficult to develop interventions or services which meet the specific needs of the street-involved population if the population itself is always moving and changing.

This heightened mobility also poses problems in regards to providing treatment and support to participants. For example, if a street-involved youth gives blood for an HIV test and, after processing the blood in a lab the result is positive, it may be extremely difficult to locate that youth to deliver the result and encourage medical attention.

And finally, at the conclusion of a study, the inability to access study participants negates the ability of the researcher to conduct member checking, the researcher sharing her notes with the participant so the participant can verify that the record and/or emerging interpretations are correct (McMillan, 2008, p.297) or to share study results with the participants (Haldenby et al., 2007, p.1242). This may negatively impact the researcher's ability to clarify any questions arising from the data, and to gain participant feedback about emerging findings.

Chapter Three - Methodology

3.1 Introduction

If simply defining prevention is a difficult task, then measuring the effectiveness of prevention is equally, if not more, difficult. In order to help guide the evaluation of prevention initiatives, a number of standards and guidelines for both the effectiveness and dissemination of research trials in the field of prevention have been developed by The Society for Prevention Research. This society is a multidisciplinary organization dedicated to advancing scientific investigation in "the prevention of social, physical and mental health…and on the translation of that information to promote health and well being" (Society for Prevention Research, 2010, Mission section, ¶1). One of these standards suggests that "prevention policies, programs and practices should be tested within real-world settings" (Hawkins et al., 2010, p.518). This standard is congruent with the evaluation plan of *Harsh Reality*, which aims to take the evaluation of this prevention initiative out of the health care facility, out of the laboratory, and into the environment of its target audience: the street.

Evaluations of health-related educational resources and programs are often categorized as process evaluations, impact evaluations, or a hybrid of the two. Process evaluations assess both the "fidelity and effectiveness of a program's implementation" (Rossi, Lipsey & Freeman, 2004, p.56). Impact evaluations may evaluate several areas of impact, both long and short-term. Impact evaluations focused on outcomes attempt to determine "whether the desired outcomes were attained" (Rossi et al., 2004, p.58). It is noteworthy that impact evaluations concerned with long-term impact often attempt to gauge "the extent to which a program produces the intended improvements in the social

conditions it addresses" (Rossi et al., 2004, p.58). The long-term impact of *Harsh Reality* on social conditions is outside of the scope of this paper. Rather, the evaluation of *Harsh Reality* involves both a process evaluation of the distribution of the resource and a short-term impact outcome evaluation to ascertain if specific educational outcomes were retained by youth who read the resource. These evaluations will be discussed in greater detail later in the chapter.

While the methodology of evaluating the process and impact outcome of *Harsh Reality* was specified in the Canadian Institutes of Health Research (CIHR) grant proposal prior to my involvement in the project, it bears merit to point out that a number of elements of *Harsh Reality* may have lent themselves well to evaluation. The following table offers suggestions of different types of evaluation, and the characteristics of *Harsh Reality* which could have provided additional avenues to explore.

Table 3.1 *Alternative Harsh Reality Evaluation Approaches*

Type of evaluation	Attempts to measure	Element of *Harsh Reality* that could be evaluated
Needs assessment	The social conditions a program is intended to ameliorate, and the need for the program	• Determining that an adolescent street-involved population does exist in Winnipeg • Determining that STI and particularly HIV are a problem for street-involved youth in Winnipeg • Determining that existing resources and services do not already offer services and interventions to effectively address this need

Assessment of program theory	The way the program is conceptualized and designed (how reasonable, feasible, ethical, and appropriate the program is)	• Evaluating the theory and implementation of the youth working group (did the group function as it was intended to, did it function with the desired outcome of youth steering the design of the resource achieved)
Assessment of program process	How well the program is operating: How consistently the services delivered are within the goal of the program, whether services are delivered to appropriate recipients, how well service delivery is organized, effectiveness of program management and use of program resources	• In addition to determining if the target population received the resource, evaluating the organization and execution of service delivery (how was delivery planned, was it executed according to the plan, etc.) • Determining if the actual budget of the project followed the proposed budget (also part of efficiency assessment)
Impact assessment	Long term: Whether the program produces the intended improvements in the social conditions it addresses	• Determining if the knowledge gained from *Harsh Reality* affected behavioural change (thus resulting in markers such as increased STI testing for street-involved youth, decreased new cases of STI and HIV, etc.)
	Short/Medium Term: Outcome: Whether the desired outcomes were obtained	• Conducting a similar knowledge uptake evaluation with any of the principal themes in *Harsh Reality* (drugs, the law, mental health, nutrition, etc.)

Efficiency assessment	Determines the relationship between a program's cost and its effectiveness (whether a program produces sufficient benefits in relation to its costs and whether other interventions can produce benefits at a lower cost)	• Determining if the actual budget of the project followed the proposed budget • Determining modifications to the project plan which could result in a more efficient use of funds (such as exploring employing a smaller youth working group, the benefits of publishing online vs. print costs, etc).

(Types of Evaluation & Definitions based on Rossi et al., 2004, p.54–60).

Similarly to how there are many different facets of *Harsh Reality* which might have been evaluated, there are multiple methods which might have been used to conduct the process and impact outcome evaluations. The following table provides some examples:

Table 3.2 *Suitability of Alternative Approaches to Conduct Process and Impact Outcome Evaluations of Harsh Reality*

Type of study	Type of problem best suited for design	Unit of analysis	Rationale for why this approach is/is not a good fit for the planned evaluation
Narrative: Exploring the life of an individual	Exploring the life of an individual	Studying one or more individuals	While an in-depth exploration of an individual's response to and experience with *Harsh Reality* could be interesting and informative, this approach is best suited to study individual participants. As such, the individual participants may not necessarily be representative of a larger group (such as

			representative of the larger population of street-involved youth). This would make it difficult to identify general trends (such as elements of the resource that were well-received by the target-audience, which knowledge outcomes were learned, etc).
Phenomenology: Understanding the essence of an experience	Needing to describe the essence of a lived phenomenon	Studying several individuals that have shared the experience	Similar to a Narrative approach, this approach could be interesting to better understand how a small group of individuals experienced *Harsh Reality*. However, while the "essence" of a participants' experience or perception of the resource is one of the guiding research questions that the evaluation hopes to address, this approach does not address specific knowledge retention or the process of distribution. Further, it is debatable if receiving a resource constitutes a "phenomenon".
Grounded theory: Developing a theory grounded in data from the field	Grounding a theory in the views of participants	Studying a process, action, or interaction involving many individuals	This approach may have been useful in evaluating resource distribution, since "process" is one of the characteristics that can be analyzed using this method. However, the goal of this approach is to develop a new theory, with the written report generally "generating a theory illustrated in a figure" (Creswell, 2007, p.79). The goal of the *Harsh Reality* evaluation was not to develop a theory of distribution or to develop a theory about specific knowledge outcomes, or youth perceptions of the resource. If, however, the evaluation wanted to focus on the process or interaction of creating the

			resource and develop a theory about the youth working group, this would be an approach to consider.
Ethnography: Describing and interpreting a culture-sharing group	Describing and interpreting the shared patterns of a culture of a group	Studying a group that shares the same culture	This approach could have been very useful if the goal of the evaluation was to study the culture of street-involved youth in Winnipeg. However, while knowledge of the culture of street-involved youth certainly informed elements of the evaluation, such as methods of distribution and physical lay-out of the resource, since the focus of this approach is on the group itself and not on the resource, it would not be an appropriate method to answer the research questions in this particular evaluation.
Case study: Developing an in-depth description and analysis of a case or multiple cases	Providing an in-depth understanding of a case or cases	Studying an event, a program, an activity, more than one individual through multiple sources of data	While a further explanation of why case study was the best method is available in section 3.2, there are several key characteristics of this approach which stand out. First is that, according to Creswell, it is the only approach that lends itself to evaluating a program – in this case, the program being the resource *Harsh Reality*. Further, case studies involve developing an "in-depth understanding of a case". This requires data collection from more than an individual (narrative) or several individuals with a shared experience (phenomenological). In addition, case studies incorporate multiple sources of data, which this evaluation intends to do.

(Information listed in Types of Study, Types of Problem Best Suited For Design & Unit of Analysis based upon "Contrasting characteristics of five qualitative approaches" in Creswell, 2007, p. 78)

While a variety of approaches may have provided different glimpses into the process and impact outcome evaluation of *Harsh Reality,* the best fit for this evaluation was the case study approach. One of the primary reasons for the selection of this method is, as with many health education evaluations, the results are not intended to generalize to all other health-related education initiatives. Rather, this evaluation aims to offer critical reflection on the one particular initiative being evaluated with the one particular population of street-involved youth in Winnipeg. A more detailed justification of the selection of the case study method will be discussed in the following section.

3.2 Rationale for Using Case Study & Case Study Design

Entering a teen crisis pregnancy centre in Winnipeg, I was overwhelmed by the amount of literature available to the clientele. Print material was not limited to information about pregnancy alone. Instead, clients were greeted with a table full of pamphlets and booklets about sexually transmitted infections, nutrition, employment, in addition to information about healthy pregnancy and various pregnancy options such as abortion, adoption, and self-parenting. In looking through the resources, I was surprised at the diverse and sometimes contradictory messaging in the various materials. One pamphlet delivered strong messaging about practicing abstinence until marriage. The pamphlet beside it offered information on healthy adolescent sexual relationships. Both resources contained information about sexual relationships, and both were directed

toward an adolescent audience. However, the information and values of the two respective pamphlets were very different. While this agency may have been trying to provide a variety of resources in order to offer "something for everyone", their mixed messaging may have been confusing, and perhaps even off-putting, to youth accessing their services.

As Hawking and colleagues point out in their study of effective community prevention practices, "the resources available for prevention, the values and priorities of community members, and the perceived fit and acceptability of various preventive interventions are likely to differ across communities" (2010, p.520). If a prevention initiative is to be effective with a particular demographic, that initiative must coincide with the lifestyle, practices, and values of the individuals it is attempting to reach. As outlined in the previous section, this evaluation does not propone to broadly evaluate and offer suggestions for all sexual health resources for all populations. Rather, this evaluation suggests a detailed look at one specific sexual health resource, and its suitability, use, and accessibility not with the general public, but with the specific population of street-involved youth in Winnipeg.

Creswell defines case study research as "a qualitative approach in which the investigator explores a bounded system (a case)…over time, through detailed, in-depth data collection involving multiple sources of information…and reports a case description and case-based themes" (2007, p.73). The evaluation of *Harsh Reality* is an intrinsic case study "in which the focus is on the case itself" (Creswell, 2007, p.74). This differs from other possible study techniques in which the focus of the evaluation might be on the participants' lived experiences or culture. To be clear, in this evaluation, the

"case" being examined is the *Harsh Reality* document itself, and not individual case studies of each of the participants. In addition to the evaluation being bound by examining the resource itself, it is further bounded by its focus only on specific objectives: retention of information, participants' perception of the resource, and efficiency of resource distribution. This is referred to as embedded analysis, which examines only "specific aspect[s] of the case" (Creswell, 2007, p.75).

Creswell identifies that "the case study researcher must decide which bounded system to study, recognizing that several might be possible candidates for this selection" (Creswell, 2007, p.76). The sexual health component of *Harsh Reality* is but one chapter amidst others that focus on topics such as the body, nutrition, drugs, rehab, mental health, legal information, and immigrant youth. While any of these chapters may have provided fertile ground for an examination, an evaluation of the resource as a whole is outside of the scope of this evaluation. In light of *Harsh Reality's* funding and support from several agencies which are focused on HIV and sexually transmitted infections, such as Kali Shiva AIDS Services and the Department of Medical Microbiology at the University of Manitoba, it was determined that the primary focus of the evaluation would be on the chapter regarding sexually transmitted infections and blood borne pathogens, with an emphasis on information pertaining to HIV/AIDS.

Similarly, the method of distribution is not the only element of process evaluation which might have been undertaken. Elements such as the process of creating *Harsh Reality*, the process of obtaining art and stories from local street-involved youth, or the process of recruiting and maintaining a youth working group, might easily have lent themselves to evaluation. However, the method of distribution was selected as a

priority in order to ascertain if *Harsh Reality* was, in fact, reaching its intended audience. Rossi et al. underscore the importance of reaching the target population with their example: "If the plan for the soup kitchen locates it a great distance from where homeless individuals congregate, it will provide little benefit to them no matter how well it is implemented" (2004, p.79). *Harsh Reality* may prove itself to be an instrumental prevention resource, but if it does not reach the intended population, its benefits will be minimal.

Creswell goes on to stipulate that "in case study research, the single case is typically selected to illustrate an issue, and the researcher compiles a detailed description of the setting for the case" (Cresswell, 2007, p.76). Yin supports this idea, stating "you would use the case study method because you deliberately wanted to cover contextual conditions – believing that they might be highly pertinent to your phenomenon of study" (Yin as per Creswell, 2007, p.76). In this case, the context of being "street-involved" becomes of paramount importance to the evaluation. The culture of "the street" is as unique as studying a culture in a foreign country. There are specific values and social morays which permeate the actions and beliefs of those who identify as part of "street culture". Despite the importance of this culture, an ethnographic approach was not the best fit as it would focus primarily on the culture itself, and not on the culture as a context in which to conduct a case study of *Harsh Reality*. Yet, an awareness of and respect for these values and this culture were integral components to beginning to develop a relationship with participants during data collection.

3.3 Research Objectives

As outlined previously, the case study of *Harsh Reality* encompasses aspects of both process and impact outcome evaluations. The process evaluation focuses on the process of resource distribution. It aims to answer the questions:

- Did the target audience of street-involved youth between the ages of 14-24 receive the *Harsh Reality?*
- If *Harsh Reality* was received by the target audience, which methods of resource distribution were most effective at reaching this population?

These questions were addressed by two sets of participants. The first group of participants was comprised of the individuals who distributed the resource throughout communities in Winnipeg. These distributors were interviewed about their experience disseminating the resource, and asked about their perceptions of the effectiveness of the method for reaching the target audience. In addition to interviewing the distributors, the youth who participated in the individual interviews were asked if they were familiar with the resource and, if so, how they had obtained *Harsh Reality*. The youth responses assisted in determining the most effective methods of distribution.

The impact outcome evaluation focused on youth's awareness and retention of specific information contained in *Harsh Reality.* The outcome evaluation broadly asked youth who participated in the individual interviews and the focus groups what information they remembered from *Harsh Reality,* and if they had acquired any new information. However, in addition to these general responses, there are three specific knowledge outcomes of interest:

- Youth knowledge of HIV testing facilities in Winnipeg

- Youth knowledge of the different types of HIV tests available
- Youth knowledge of Research Round-Up articles

Harsh Reality contains four Research Round-up articles interspersed throughout the 240 page resource. Ranging in length between 1/2 a page to 2 pages, each Research Round-Up article is a summary of a recent formal research study that has been undertaken in Manitoba. The following table illustrates the four Research Round-up articles, and the studies they were based on.

Table 3.3 *Research Round-Up Articles and Corresponding Studies*

Title of Research Round-Up article	Title of study as listed in *Harsh Reality*
"Rates of skin infections with antibiotic-resistant bacteria are on the rise in Manitoba"	"Rapid emergence of MRSA among children and adolescents in northern Manitoba" (Larcombe, Waruk, Schellenberg, Ormond, 2007)
"Good bacteria protect your bits from STD and HIV"	"The good bacteria study"(Schellenberg, Ball, Lane, Cheang & Plummer, 2005)
"Rates of STI are really high in Winnipeg street youth regardless of who you are or what you do!"	"Respondent-driven sampling in street-involved youth study" (Thompson, Schellenberg, Ormond & Wylie, 2007)
"Female Caucasian meth users more likely to share needles"	"Social networks in IDU study" (Wylie, 2006)

In addition to specific knowledge outcomes, the outcome evaluation also asked youth about their general impressions of the strengths and weaknesses of *Harsh Reality*. This allowed youth to offer their feedback on aspects of the resource such as visual appeal, content, and layout. This included both quantitative and qualitative impressions. For example, youth were asked to identify their opinion of the graphics of *Harsh Reality* based on a Likert scale of responses (strongly dislike, dislike, neutral, like, strongly like) (McMillan, 2008, p.169). Youth were also asked to anecdotally identify elements that

they liked and/or disliked about the resource. These elements might have included youth's perception of the layout of *Harsh Reality,* the content, the graphics, and the language used throughout the resource. The specific elements will be further described later in the chapter.

3.4 Data Collection

3.4.1 Sources of data collection.

One of the hallmarks of the case study design is that it necessitates "in-depth data collection involving multiple sources of information" (Creswell, 2007, p.73). Again, this supports the use of a case study design because, since the inception of the project, data was intended to be collected from a variety of sources. Yin outlines six different kinds of information that can be collected for a case study, namely: "documents, archival records, interviews, direct observations, participant-observations, and physical artifacts" (Yin as per Creswell, 2007, p.75). The sources of data used in the *Harsh Reality* evaluation include:

- The *Harsh Reality* resource itself
- Individual participant interviews involving both quantitative and qualitative questions
- Focus groups in which questions similar to the individual participant interview questions were asked. The results from both the individual interviews and focus groups will be compared to see what similarities and/or differences arise from using the two different formats
- Interviews with distributors

- Researcher observations and critical reflections. Researcher observations include observations of youth reading through or discussing *Harsh Reality*. Critical reflections include reflections on data provided by participants, in addition to reflection upon the experience of evaluation design, implementation, and interpretation of data
- Reviewed literature on HIV/AIDS education, preventative education, and street-involved youth

In his writings about case study, Yin highlights that "bringing qualitative and quantitative evidence and methods together will be the special strength of [using] the case study method" (Yin, 1994, p.287). The collection of both quantitative and qualitative data during the individual interviews and focus groups assist in providing multiple formats to attempt to accurately capture the opinions and perspectives of the participants.

3.4.2 Perspectives represented in the data.

The inclusion of multiple sources of data allows the case study to draw upon the perspectives of multiple stakeholders and participants involved in the evaluation. The following table outlines the diverse perspectives represented through the multiple sources of information used in this evaluation.

Table 3.4 *Perspectives Represented in the Harsh Reality Evaluation Data*

Perspective	Sources of information
Researcher/Program evaluator	• CIHR Catalyst grant • Meetings and correspondence, and advice from academic advisors: Dr. John Wylie, principal investigator of CIHR grant, Dr. Catherine Casey, committee member & Dr. Barbara McMillan, advisor, 2008 - 2011 • Interaction with *Harsh Reality* distributors, both planning and executing distribution • Meetings, email correspondence, and notes from *Harsh Reality* coordinator, Margaret Ormond 2008 – 2011 • Data from individual interview participants • Data from focus group participants • Personal experiences and reflections • Critical reflections on literature and data • Observations of youth reading or discussing *Harsh Reality* • Literature relevant to the evaluation • Access document, Excel document tracking contacts, and anecdotal data summary
Individual interview participant	• *Harsh Reality* • Information from researcher both prior to and during the interview
Focus group participant	• *Harsh Reality* • Information from researcher both prior to and during the focus group • Information about the purpose and format of the focus group from the recruiting community based organization
Distributors	• *Harsh Reality* • Participation in the planning and/or execution of *Harsh Reality* distribution • Information from researcher both prior to and during the interview
Funding partners	• *Harsh Reality*

• University of Manitoba, Department of Medical Microbiology • The Public Health Agency of Canada • Kali Shiva AIDS Services • *Harsh Reality* Youth Working Group and coordinator	• CIHR grant proposal
Advisory committee • Dr. Barbara McMillan (advisor) • Dr. John Wylie • Dr. Catherine Casey	• Meetings and email correspondence 2008 - 2011
Theoretical perspectives • AIDS/STI education • Health-related prevention interventions • Working with street-involved youth	• Literature review (all cited) • AIDS/STI education pamphlets, resources, and websites

3.5 Data Collection Process

Due to the interviews and focus groups involved in the data collection for this evaluation, ethical approval was necessary. Ethical approval was received in June, 2009 from the Health Research Ethics Board of the University of Manitoba (see Appendix A).

It was not necessary to obtain ethical approval from the Education and Nursing Research Ethics Board as no additional data was collected under the authority of research for this thesis.

The following table outlines the type of data to be collected, and the means of collecting these data.

Table 3.5 *Data Collection: Methods and Instruments*

Method of collection	Data type
Individual Interviews	• Contact tracking sheet • Oral Questionnaire • Researcher's notes during the interview
Focus Groups	• Contact tracking sheet • Audio recorded conversation • Transcript of recordings • Researcher's notes and Margaret Ormond's notes taken during the focus group
Distributors	• Oral Questionnaire • Researcher's notes during the interview

3.5.1 Overview of data collection process: Individual interviews.

For the individual interviews, an opportunistic sampling method was used (McMillan, 2008, p.121). Participants for individual interviews were recruited from multiple locations in Winnipeg where youth, specifically street-involved youth, often spend time. Examples of these locations include Portage Place, City Place, the Forks Skate Park, Osborne Village, and Resource Assistance for Youth (RaY). These locations were selected both from my own observations of popular locations, and from suggestions and conversations with *Harsh Reality* distributors. Distributor input enabled the evaluations to take place in locations which largely mirrored regions of distribution, concentrated in Central, North and West Winnipeg.

The evaluation of *Harsh Reality*, as outlined in the CIHR grant, stipulated a sample size of 100 individual interviews. A formal sample size calculation was not used to determine this number. Instead, a sample size was chosen that appeared feasible in terms of data collection, yet would still give a good indication of any problems that would likely be encountered. However, despite the random selection of the number 100,

this sample size can be expressed in terms of the descriptive nature of categorical variables. First, the sample size is non-random so a design effect of 2 is commonly used. Therefore, 100 participants from a convenience sample may be approximately equivalent to a random sample of 50. For variables with an expected proportion of .15, a sample of 49 will have a 95% confidence level, with a total confidence width of .20 (Hulley, Cummings, Browner, Grady & Newman, 2007).

It is important to note that youth who were approached but who were not familiar with *Harsh Reality*, were outside of the target age range of 14-24, or were under the influence of drugs or alcohol were not eligible to participate in the interview. However, every youth contacted was recorded on a Contact Tracking Sheet. The following is an example of a Contact Tracking Sheet.

Figure 3.1 Example of Contact Tracking Sheet

	Contact #1	Contact #2	Contact #3	Contact #4
Male	x	x		
Female				
Transgender				
Caucasian	x			
Aboriginal				
Black		x		
Other				
Less than 14	x			
Between 14-24		x		
More than 24				
Saw *HR* before*		x (cousin)		
Gave *HR* *	x	x		
Completed Interview		x		
Location	City Place	Portage Place		

* *HR* denotes *Harsh Reality*

The Contact Tracking Sheet was designed to accommodate a quick and efficient method to record basic demographic information about the youth approached for the evaluation. Each Contact Tracking Sheet also provided a space to record the date and time that the youth was approached. Periodically, throughout data collection, the information from the Contact Tracking Sheet was compiled in an Excel document. It is important to note that for youth who did not complete the individual interview, characteristics such as gender and ethnicity were based on observation (youth were asked to identify these factors if they participated in the individual interview).

In order to recruit participants, youth were approached, shown *Harsh Reality*, and asked if they were familiar with the resource. "Familiar with the resource" can be defined as recognizing the cover, the title, or having received or read a copy. In addition to showing the youth the most current edition of *Harsh Reality*, the youth was also shown the cover art from previous editions and asked if he was familiar with earlier editions. If the youth was not familiar with *Harsh Reality*, the youth would be offered a copy of the resource and the interaction was recorded on the Contact Tracking Sheet.

If the youth indicated he had looked through *Harsh Reality*, not just seen the cover, I proceeded to explain the *Harsh Reality* evaluation. This explanation included the following: describing the purpose of the evaluation, explaining the format of the interview (including anonymity of responses), ensuring the youth was within the target age range of 14-24, describing that a $10 honoraria would be provided for participation, providing assurance that the youth could cease participation at any time without penalty, and obtaining the youth's oral consent to participate. One consent form was completed for each participant. After obtaining oral consent, I signed and dated each form to

indicate that the pertinent information had been explained to and understood by the consenting youth. Youth who participated in the evaluation were also recorded on the Contact Tracking Sheet.

It is noteworthy that, in the case of this evaluation, ethical approval was requested and granted for participants between the ages of 14–18 to provide their own oral consent in lieu of obtaining consent of a parent or guardian. Several arguments provided the rationale for this exception. Firstly, many youth who are street-involved are living independently of their parents or guardians. In light of the transient lifestyle of many street-involved youth, it would prove very difficult to obtain consent from these youth's guardians. Further, due to the method of participant recruitment, that is, approaching youth in the community, a requirement for youth to seek consent from a third party could result in substantial loss of participants who, if they could consent themselves, would be willing and able to participate. And lastly, despite some sensitive information included in *Harsh Reality*, the questions asked of the participant in the individual interview were not of a sensitive nature. With the exception of the interview's initial general demographic information (age, sex, level of education, ethnicity – all of which participants may decline to answer), the questions in the individual interview did not ask youth to describe activities that they may/may not participate in. Rather, the questions focused almost exclusively on content and appearance of *Harsh Reality.*

The individual interviews utilized a mixed-method approach and incorporated both quantitative and qualitative questions. James McMillan (2008) outlines that there are three types of interview questions used in educational research: structured,

semistructured and unstructured questions. According to McMillan's definitions, the individual interviews employed two of these types of questions.

- Structured questions offered participants a number of predetermined options to choose from (McMillan, 2008, p.177).

  Example: What did you think of the look of *Harsh Reality* (pictures, graphics, etc.)?

  Possible responses: Strongly like, like, neutral, dislike, strongly dislike.

  These structured responses were then followed by probing questions in order to better understand why participants selected a particular response.

- Semistructured questions allowed open-ended individual responses yet were specific in intent (McMillan, 2008, p.177).

  Example: Was there anything you learned from *Harsh Reality*?

  Example: What do you dislike about *Harsh Reality?*

  Semistructured questions also lent themselves well to following the initial question with probing questions. For example, in response to the question "What do you dislike about *Harsh Reality?*", if the participant responded "Nothing", the researcher could follow-up with more specific questions such as "So you thought the graphics were ok?" or "So there was no information in there that made you think 'why is this in here?'"

For a complete list of the questions used in the individual interview, please consult Appendix B. To view the consent form used for the individual interviews, please consult Appendix C.

Participant responses were written by the interviewer on the individual interview question sheet. As much as possible, effort was made to record verbatim participant responses.

At the conclusion of the interview, participants were given $10 in cash and asked to initial an Honorarium Form indicating they had received the money. The Honorarium Form recorded the following information:

Figure 3.2 Example of Honorarium Form

Participant Number	Date	Location	$10 Received
1.	Sept 12/2009	Portage Place	MH
2.	Sept 12/2009	Dollorama on Portage	PJ

Following the interview, the consent form and corresponding individual interview sheet were folded so that the consent form and interview responses would not separate. These folded papers were transferred to a locked filing cabinet in my home office.

Often, youth in the community can be found in pairs or small groups. In these cases, I would approach the group or pair of youth to initiate conversation about whether or not they were familiar with *Harsh Reality*. If the youth were familiar with the resource and indicated interest in participating in the individual interview, I would obtain consent and administer the interview with an individual youth at a distance away from the group. Administering the interview individually allowed the youth to express herself without concern that her friends might be listening to the responses. In addition, the validity of responses to questions such as “Do you remember reading/seeing any

articles called 'Research Round-Up?'" might be compromised if youth overheard a fellow participant's responses.

At the conclusion of the interview and after the participants received their honoraria, I would often offer the participants resources such as condoms and/or granola bars (based on availability of supplies). If participating youth asked specific questions such as where to get tested for STI, or sought information about community resources, referrals to agencies were recorded on the Contact Tracking Sheet.

3.5.2 Overview of data collection process: Focus groups.

The focus group component of the evaluation included three focus groups. Each focus group aimed to include between 8–10 participants in the same target age range as the individual interview participants (14–24 years). The focus groups were gender stratified: one female group, one male group and one mixed gender group. The purpose of this gender stratification was to ascertain if divergent or similar themes emerged among the various groups. Following the rationale provided in the previous section, youth between the ages of 14-18 were able to grant their own consent to participate in the focus groups. To view the consent form used for the focus groups, please consult Appendix D.

To recruit participants for the focus groups, a mixture of both opportunistic and convenience sampling was used. Margaret Ormond, the research nurse who coordinated the *Harsh Reality* youth working group, has extensive experience working with the street-involved community in Winnipeg. Margaret contacted staff at two community resource centres, Resource Assistance for Youth (RaY), and Magnus Eliason Recreation

Centre (MERC) (in different areas of the city) where *Harsh Reality* had been distributed. All of the community resource centres (CRC) can be described as youth-serving organizations. In this context, a youth-serving community resource centre is an organization that offers community outreach to youth in the forms of recreation programs, skills training, or resources and basic amenities such as food, internet access, shower facilities, and the like. The selected organizations actively build and foster relationships with the target demographic of street-involved youth. The selection of community resource centres based on Margaret's existing contacts, in addition to the knowledge that *Harsh Reality* was distributed both at the CRC and in the surrounding neigbourhood, is congruent with McMillan's definition of convenience sampling, "a group…selected because of availability" (2008, p.118).

The community resource centre staff was asked to recruit 8-10 potential participants who met the gender and age criteria for the focus groups. Opportunistic sampling was used by the staff to select youth who were present at the time of participant recruitment, and to gauge their interest in focus group participation. When a suitable number of youth participants had been recruited, a date and time were selected to hold the focus group at the community resource centre where the youth had been approached. The staff person communicated the date and time to the youth participants.

For the third focus group, an additional community resource centre was selected: Sunshine House. Instead of recruiting youth who were involved at the community resource centre, this focus group would be comprised of various street-involved youth who had previously indicated interest in participating in an evaluation of *Harsh Reality*. These youth from various locations and social groups agreed to meet at Sunshine House

at a pre-arranged date and time. The participants in this group were selected using convenience sampling of individuals already known by either Margaret or myself.

In addition to convenience sampling, opportunistic sampling was also employed due to the difficulty of communicating with street-involved youth. As discussed in Chapter 2, transience and mobility are hallmarks of this population, and few street-involved youth have access to a regular phone number or consistent email. As a result, youth who were visible and easy to access were the individuals invited to participate in the third focus groups.

The following table summarizes the locations, and gender stratifications of the focus groups:

Table 3.6 *Planned Number of Participants, Locations, Recruitment Method, and Gender of Focus Groups*

Number of Participants	Location	Method of Recruitment	Gender
8 – 10	Resource Assistance for Youth	Staff of CRC* recruited youth	Male
8 – 10	Magnus Eliason Recreation Centre	Staff of CRC* recruited youth	Female
8 - 10	Sunshine House	Youth recruited by existing contacts with researcher & research nurse	Male & Female

* CRC indicates Community Resource Centre

The physical set-up of each focus group was consistent; the participants and I sat in a circle of chairs surrounding a number of tables. Margaret sat on the periphery of the group and took notes during the focus group discussions. Snacks, such as juice boxes and cookies and/or granola bars, were provided for each group. Copies of *Harsh Reality*

were available on the table should participants want to refer to something specific in the resource. During each focus group, a Zoom audio recorder was placed in the centre of the table.

To commence the discussion, I provided an explanation of the focus group to the participants. Similar to the individual interviews, this explanation involved describing the purpose of the evaluation, explaining the format of the discussion (including anonymity of responses), ensuring the youth were within the target age range, describing that a $20 cash honorarium would be provided for participation, and providing assurance that youth could cease participation at any time without penalty. When discussing the anonymity of responses, I also explained that information shared by fellow participants during the focus group should remain confidential. In addition to obtaining the youth's oral consent to participate in the focus group, each youth was also asked to provide oral consent to have the conversation audio recorded.

The questions used in the focus group were identical to the questions used for the individual interview (please see Appendix B). This was done to facilitate comparison of similarities and differences which might occur between the responses from the individual interviews and responses from the focus groups. During the focus group conversation, I posed a question to the group and then facilitated the participants' responses. Contrary to the individual interviews, each participant was not asked each specific question, but could choose when to participate in the dialogue. I strove to facilitate a balanced conversation, attempting to include quieter participants by asking them about their opinions, and allowing more vocal participants to share their opinions but not dominate the group. During the conversation, I wrote down key points on a

notepad. Margaret took notes for the duration of the focus group. Margaret's notes were included as a data source and used to corroborate my own notes. For example, if in response to the question "How many people have seen *Harsh Reality 3*?" multiple participants raised their hands, after the focus group, I would compare the number of people I recorded with raised hands to the number of people Margaret recorded in order to ensure that I had counted accurately.

Following the focus group, each participant received a $20 honorarium and initialed on a sheet identical in format to the Honorarium Form used for individual interviews. A larger honorarium was provided for focus group participants due to the greater amount of time required for participation.

Upon completion of the focus groups, I transcribed the audiotapes into Word documents. In addition to the transcribed dialogue, the notes written by both myself and Margaret were compiled, added as "observations" to each transcript, and included as supplementary data to the conversation.

3.5.3 Overview of data collection process: Distributors.

In the context of this evaluation, a distributor can be defined as an individual who participated in the dissemination of *Harsh Reality* in one or more of the following capacities:

- Formal Distributor: An individual employed as a distributor by the *Harsh Reality* working group. This distributor received hourly monetary compensation for walking through areas of Winnipeg and providing outreach

to youth by distributing *Harsh Reality* resources in addition to condoms, granola bars and, when available, clean syringes.

- Informal Distributor: An individual who was not necessarily employed as a distributor, and did not receive monetary compensation for distributing *Harsh Reality*. This distributor took multiple copies of *Harsh Reality* and distributed them through his personal informal social networks. Examples include giving resources to friends, family members, community members, or people at a party or social gathering.
- Distributor through Position: An individual who was not employed as a distributor, and did not receive monetary compensation for distributing *Harsh Reality*. This distributor was either employed or volunteered for a youth-serving community resource centre. Through this individual's employment/volunteer position, she distributed *Harsh Reality* to the target audience.

Several of the distributors could be classified as more than one type of distributor. One example would be an individual who is employed to distribute *Harsh Reality* by walking through popular locations in Winnipeg, and this person also hands out copies of the resource to personal friends and family (both a formal and informal distributor). Margaret, who had overseen the recruitment of distributors, provided me with the distributors' contact information. I contacted distributors individually, and a time and location, specified by the distributor, were chosen for the interview. At the interview, similar to the individual interviews and the focus group, I began by explaining the purpose of the evaluation, the format of the interview (including anonymity of

responses, describing that a $20 cash honoraria would be provided for participation, and assuring the distributor that participation was voluntary). Each distributor signed a consent form indicating his or her willingness to participate in the interview. To view the distributor consent form, please consult Appendix E.

During the interview, distributors responded to oral questions. The questions were not identical to the questions used for the individual interviews and focus groups. Instead, the questions involved topics such as the distributor's involvement (if any) in creating *Harsh Reality*, how the distributor became involved in distributing *Harsh Reality*, the methods of distribution used, and the distributor's impressions of the resource and the distribution process. During the interview, I wrote down the distributor's responses to the questions. To view the questions used in the distributor interview, please consult Appendix F.

Upon completion of the interview, each distributor received a $20 honorarium and signed on a sheet identical in format to the Honorarium Form used for individual interviews and the focus groups. As with all of the hard-copy documents containing data from this evaluation, the consent forms and notes from the distributor interviews were stored in a locking filing cabinet in the same office.

Chapter Four – Case Study

4.1 Data Collection for Individual Interviews: Context & Dynamics

Data collection for the individual interviews took place between October 7th, 2009 and March 17th, 2010. During these six months, I went out into the community independently, or with Margaret, in order to recruit participants. While I had originally anticipated being able to easily find individuals who were familiar with *Harsh Reality*, early in the data collection process, it became apparent that this was not as easy as originally planned. As a result, while individuals who had previously seen *Harsh Reality* were preferred, if an individual had not seen *Harsh Reality* but was amenable to taking time to read through the resource and then complete the individual interview, that individual was eligible to participate in the survey. It was recorded on the Contact Tracking Sheet if the participant had seen *Harsh Reality* previously, or if the participant saw the resource for the first time on the date of the evaluation.

In total, 375 individuals were contacted at 62 locations during individual interview data collection. The following table lists the location, number of contacts, and number of surveys completed at each location.

Table 4.1 *Distribution of Individual Interview Contacts and Participants by Location*

Neighborhood	Location	Type of location	Number of Contacts	Number of surveys completed
Area: Downtown				
1	MTS Centre	Public Venue	2	1
2	Portage Place	Mall/Store	56	20
3	Vaughan	Street	1	1
4	Edmonton	Street	3	0
5	City Place	Mall/Store	16	1

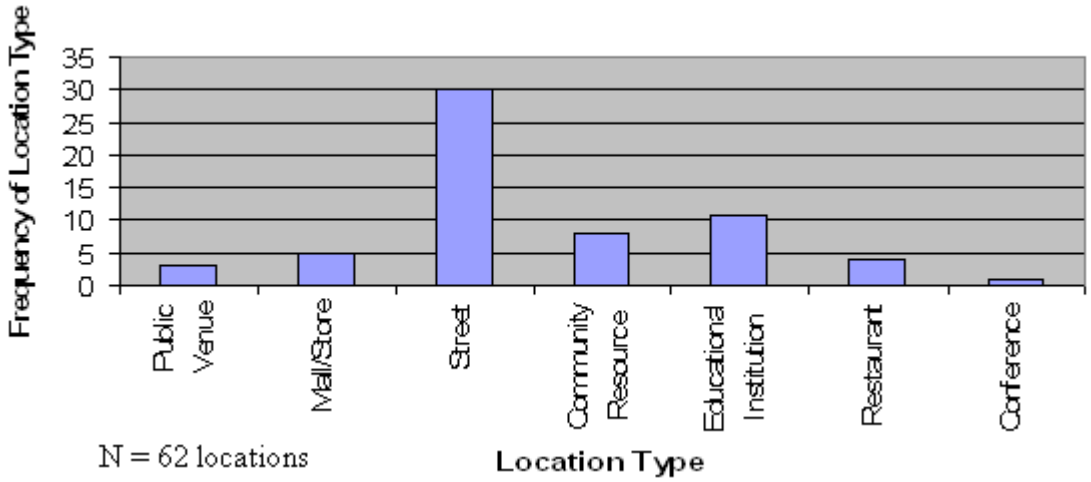
6	YMCA Downtown	Community Resource	1	0
7	The Bargain Shop	Mall/Store	11	3
8	TERF on Portage	Educational Institution	1	0
9	U of W	Educational Institution	5	1
10	Portage & Sherbrook	Street	8	2
11	Dollorama on Portage	Mall/Store	6	4
12	Portage & Edmonton	Street	2	2
13	Portage & Maryland	Street	5	1
14	Portage & Broadway	Street	3	0
Area: The Village				
15	Osborne	Street	11	0
16	Osborne & Ellice	Street	2	0
17	River & Osborne	Street	9	8
18	Osborne & Sherbrook	Street	3	0
19	Osborne & Pembina	Street	3	2
20	River & Pembina	Street	1	1
21	Broadway & Osborne	Street	11	6
22	Osborne & Gertrude	Street	3	0
Area: North End				
23	Selkirk Avenue	Street	9	1
24	Ndinawe	Community Resource	4	0
25	Salter Street	Street	7	0
26	McDermot Street	Street	1	0
27	Kate Street	Street	1	0
28	Isabel	Street	5	0
29	Adult Education Centre on Memorial	Educational Institution	3	0
30	Robins Donuts on Selkirk	Restaurant	2	0

31	Children of the Earth School	Educational Institution	1	0
32	Dufferin & Salter	Street	8	0
33	RB Russell School	Educational Institution	7	0
34	Neechi Foods	Restaurant/ Mall/Store	2	0
35	Selkirk & Salter	Street	3	0
36	Songadewin Alternative School	Educational Institution	3	0
Area: West End				
37	RaY	Community Resource	2	2
38	Bridge near Misericordia Hospital	Street	1	1
39	Tim Hortons on Maryland	Restaurant	3	3
40	McDonalds on Portage Avenue	Restaurant	8	3
41	Balmoral	Street	1	0
42	Broadway & Good Street	Street	5	3
43	Broadway & Sherbrook	Street	4	1
44	Broadway & Gertrude	Street	2	0
45	Gordon Bell School	Educational Institution	3	0
46	Broadway & Maryland	Street	3	2
47	New Directions in Young United Church	Community Resource/ Educational Institution	2	0
48	Sherbrook & Westminster	Street	3	0
49	Maryland	Street	1	1
Area: The Core/ Point Douglas				
50	Salvation Army	Community Resource	3	0
51	Siloam Mission	Community Resource	3	0

52	Aboriginal Education Centre	Educational Institution	2	1
53	Rossbrook House	Community Resource	3	0
54	Sunshine House	Community Resource	8	8
55	KFC on Notre Dame	Restaurant	2	0
56	Main & Higgins	Street	2	1
57	Thunderbird House	Community Resource	2	0
Area: The Forks				
58	Forks Skate Park	Public Venue	31	10
59	The Forks	Public Venue	5	2
Area: Other				
60	Vincent Massey	Educational Institution	4	3
61	AIDS Conference at Victoria Inn	Conference	52	4
62	Acadia Junior High	Educational Institution	1	1
			375	100

Based on the data from the preceding table, Figure 4.1 represents the frequency of the various types of locations where individual interview participants were recruited.

Figure 4.1 Distribution of types of locations used to approach individual interview contacts



As displayed in the graph, the majority of individuals contacted were approached directly in the community/"on the street" (30 locations out of 62). The second most common location where individuals were contacted was near or on the grounds of educational institutions. It is important to note that several of the educational institutions could be classified as "alternative schools": school which offer adapted programming for individuals who may have experienced challenges in a traditional school setting (for example: Songadewin School, Transition Education Resources for Females (TERF), and the Aboriginal Education Centre). Individuals contacted at or in the vicinity of schools were outside of the institution and smoking, waiting for a bus near the school, or near school grounds after school hours. No individuals were contacted within educational institutions during school hours.

Gaining the confidence to approach someone on the street and begin a conversation was definitely something that required practice. For that reason, I am

indebted to Margaret, who made the time to go out into the community with me and model the art of striking up a conversation. While initially many safety precautions were taken, such as always going out to do data collection with Margaret or with a third party who could walk around with me, those precautions often fell to the wayside due to the challenges of trying to coordinate scheduling. For example, if I was available to go out and do data collection and no one else was available to accompany me, I was not prepared to give up that opportunity. In some circumstances, there were exceptions. For example, I would not walk around downtown late at night in the dark by myself. However, during the day and in the early evening, I felt comfortable going out by myself. As additional safety considerations, each time I planned to collect data in the community I would have my cell phone with me, and I would often phone a "safety contact" at the beginning and end of these data collection outings.

In approaching people, I did not encounter any situations where I felt I was in danger. There was one instance when I was trying to do an interview with a male, and his buddies, who were extremely drunk, kept approaching us and interrupting. The participant was getting mad at the interruptions, and his friends were becoming more and more persistent at joining the conversation. I was nervous that their interaction might escalate into a fight. So, in an effort to extricate myself from the situation, we skipped a few of the questions on the questionnaire. Other than that minor incident, data collection did not cause me to feel unsafe.

Substance use in potential participants was something I learned more about as I gained experience collecting data. I learned that there would tend to be more people using substances on days that social assistance cheques were issued. Friday and Saturday

nights generally presented as times when people who were out and about would be more likely to be under the influence of a substance. Usually, there were fewer potential participants hanging around downtown on Saturday and Sunday mornings before noon. Learning these types of rhythms was instrumental in planning the most effective times to go out and do data collection. As one example, Portage Place, both in the morning around 8:30 a.m. and around 3:00 p.m. tends to be quite crowded with people between the ages of 14-24. I learned that to interact with people who aren't necessarily attending school, the Forks Skate Park is a good place to visit on weekdays between 1:00 and 4:00 p.m. The people who panhandle or squeegee in Osborne Village tend to be easiest to find during the 4:00 p.m. to 6:00 p.m. rush hour, when traffic is heaviest.

On several occasions, potential participants were convinced that I was an undercover police officer. This was especially the case if I was approaching someone who was squeegying or a lone female who may have been working in the sex trade. However, in general, the people I approached were receptive to talking about or receiving the resource, and were pleasant to interact with once I was able to explain the purpose of the evaluation.

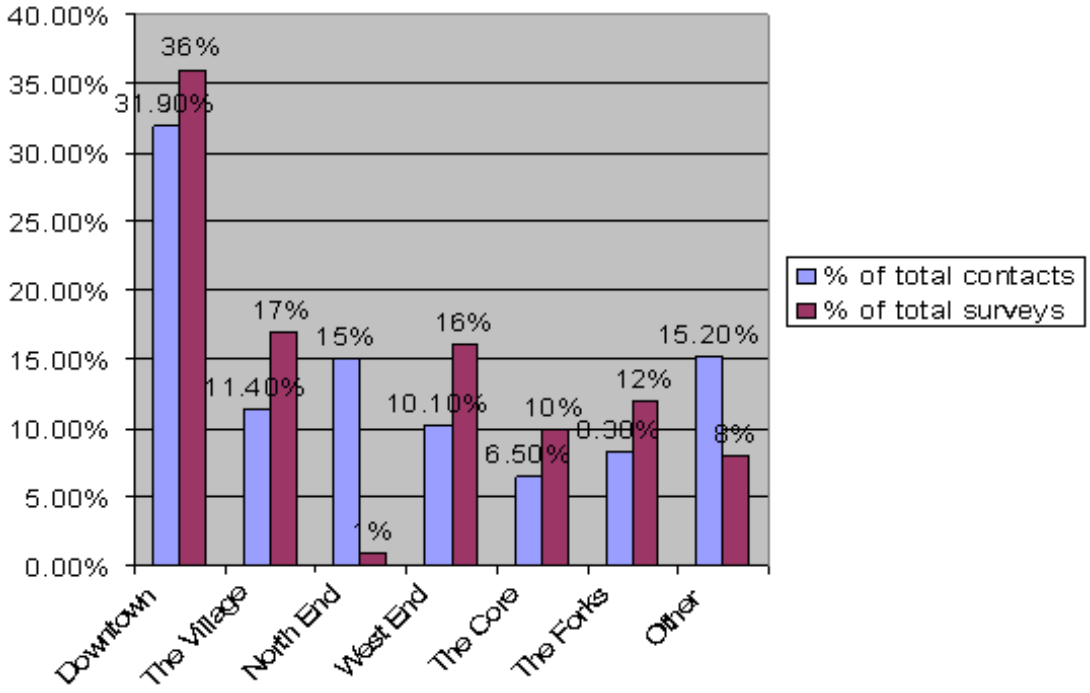
I tried to be very aware of my own biases when doing data collection. I am aware that, for myself, I feel more comfortable approaching males than females. In my experience, males were friendlier and less intimidating than the females. Also, as an informal mental tally, I think females more often declined to engage in a conversation that I initiated than males. As a result of this awareness, a conscious effort was put forth to approach both genders equally. Becoming aware of this bias proved useful, as the gender distribution of the 375 contacts was almost equally split; 53% of the contacts

were male and 47% were female. None of the individuals contacted self-identified as transgender, or were identified by observation as being transgender.

The question pertaining to participant gender proved to be one of the more challenging questions in the individual interview. Before commencing data collection, I had anticipated that the inclusion of a "transgender" category, in addition to the traditional "male" and "female" options, would be an effective strategy to make participants feel comfortable sharing information about their gender. Also, I made an effort to ask participants "What is your gender?" instead of making an assumption based on their physical appearance. However, while asking participants their gender may have made some people feel more comfortable, the question also appeared to bother some participants. On several occasions after asking someone "What is your gender?" the individual seemed to be offended and asked me "Well, don't I look like a girl?", or "You can't tell I'm a guy?" In these instances, I explained that I was obligated to ask each person instead of making an assumption. This seemed to make sense to people who appeared offended. However, I had not anticipated that the question about gender would pose one of the more sensitive questions to navigate – and that the sensitive nature of the question was problematic not necessarily for a marginalized group, but for the mainstream genders.

As outlined earlier, participants were recruited from a variety of neighbourhoods in Winnipeg. The following graph represents the percentage of the total contacts which took place in the different geographic neighbourhoods, and the percentage of the 100 individual questionnaires that took place in the same neighbourhood.

Figure 4.2 Percentages of contacts and surveys separated by neighbourhood



There is a notable disparity between the number of individuals contacted in the North End of Winnipeg and the number of surveys completed. This may be attributed to several factors, including the following. The majority of the individuals contacted in the North End had not heard of *Harsh Reality*. This may have resulted in the individuals being less likely to take the time to read through the resource and then complete the survey than individuals who were previously familiar with *Harsh Reality*.

In addition, many of the individuals contacted in the North End were walking on their way to another location. Approaching individuals in transit to a location may be less successful than approaching individuals who are already at a location (for example: the difference between approaching kids hanging-out on school grounds playing basketball, or a youth on her way to meet friends to play basketball). Furthermore, the

North End of Winnipeg is known by many Winnipeggers to be a "dangerous" area. Therefore, potential participants may have been less likely to stop and talk to a stranger approaching them than potential participants in different Winnipeg neighbourhoods.

The "other" category of the graph accounts for youth who were contacted during the Metis and Manitoba First Nations AIDS Working Group AIDS Conference held at the Victoria Inn between February 16th & 17th, 2010. However, while many youth at the conference expressed interest in *Harsh Reality* and accepted a copy from Margaret or me, only 4 of the 52 individuals who received the resource returned to the booth to complete a survey.

4.2 Data Collection for Focus Groups

Each of the focus groups will be described in individual detail below. The following table summarizes the date, the number of participants and the duration of the three focus groups.

Table 4.2 *Date, Number of Participants, and Duration of Focus Groups*

Date	Number of female participants	Number of male participants	Duration of focus group
June 6th, 2010	1	6	45 minutes 03 seconds
June 9th, 2010	6	0	26 minutes 21 seconds
June 10th, 2010	0	10	55 minutes 35 second seconds

4.2.1 Data collection for focus groups – mixed gender focus group: Context and dynamics.

The mixed gender focus group took place on June 6th, 2010 at 2:00 p.m. The focus group was originally scheduled to take place on Saturday, June 5th, 2010 but a variety of challenges resulted in the rescheduling of the group.

As previously outlined, the original plan for the mixed gender focus group was to recruit street-involved individuals who were not affiliated with a particular organization (shelter, clinic, program, and the like). Through her existing network of contacts, Margaret recruited 6 participants and advised them of the date and time of the focus group. Participants were also advised of the location, Sunshine House, a well-known community resource centre near the Health Sciences Centre.

On June 5th, I met Margaret at Sunshine House 30 minutes before the focus group was to begin. At the designated start time, no participants had arrived. After waiting an additional 20 minutes, Margaret and I agreed that I would stay at Sunshine House (in the event a participant showed up) and Margaret would go to locations in the community where the participants often congregated to see if she could locate several or all of them.

Approximately 45 minutes later, Margaret returned to Sunshine House. During the 45 minutes that I waited at the location, no focus group participants arrived. Margaret informed me that she had encountered the 6 original participants. However, all of those 6 youth were at the Ellice Street Festival and appeared to be inebriated. As a result, due to ethical concerns about their heightened vulnerability as a result of

substance use, in addition to their inability to provide informed consent, they were ineligible to participate.

Subsequently, Margaret explained that she had walked around the surrounding area in an attempt to find other candidates who might be interested in participating in the focus group. In walking around, Margaret encountered a group of youth smoking outside of Ndinawe (a community resource centre). Margaret approached the group, explained what the focus group was about, and asked if they would be interested in participating. According to Margaret, some youth expressed that they were interested, some expressed that they were not, and some shared that they had friends who would probably want to participate. One of the people standing outside with the youth was a staff person at Ndinawe. Margaret made arrangements with the staff person and agreed to come to Ndinawe the following afternoon, pick up the youth who were interested in participating (in addition to the staff person), and drive them all to Sunshine House to participate in the focus group. Margaret and I agreed to attempt the focus group on the following afternoon (Sunday, June 6th).

On the afternoon of June 6th, I arrived at Sunshine House and Margaret let me in to set-up for the focus group. This involved moving several of the tables into a circle in the centre of the room, putting out a snack of granola bars and canned juice, putting out copies of *Harsh Reality* that could be referred to throughout the discussion, and arranging the audio recorder. During this time, Margaret drove to Ndinawe and brought back the participants for the focus group: 6 male participants, 1 female participant, and 1 male staff member. I sat in the circle around the central table with the participants and staff member. Margaret sat on the periphery of the circle and took notes during the

conversation. All participants granted oral consent both to participate in the focus group and to have the conversation recorded.

In general, I felt that this focus group went very well. As this was my first time facilitating a focus group, I was initially nervous about what to do in the event of long awkward silences during the discussion. However, that was not the case. The group seemed eager to participate and share their experiences and opinions about *Harsh Reality*. While I had hoped that the ratio of male to female participants in the group would be more equally divided, the female participant did participate and share her responses (voluntarily for the first half of the group, and if invited during the second half of the group when she was occupied on her cell phone). In some instances, she was able to provide information that offered a unique perspective from what the males had expressed (for example during a discussion about prescription drugs, the males discussed taking prescription drugs voluntarily for recreation, while the female participant shared that someone had slipped a prescription drug in her drink at a party).

The general dynamic of the group was upbeat and, while there were some instances of joking around, in my opinion, these jokes were good-natured and not intended to hurt the feelings of those being joked about. Rather, the person who was being joked about appeared to find the comment humorous. The following example is taken from the transcript of the mixed gender focus group:

> Chelsea: What are the things that are most important for people your age to know about? These can be things from *Harsh Reality* or things that just come into your head.
>
> Participant: Drugs.

Participant: Sex.

Participant: Drugs, sex and alcohol…

Chelsea: Somebody said sex. What parts of sex?

Participant: I think people like (name removed) and (name removed) would really benefit from finding out different sexual positions (people laugh).

During the focus group, I noted that one participant in particular, who will be referred to as Jim, often had a lot to say in response to the questions. While Jim's responses were welcome, I also strove to include other more reserved participants in the discussion. This was facilitated primarily by asking specific people if they had anything to add or to say about the topic being discussed. The staff person from Ndinawe appeared to pick-up on how I was attempting to include everyone in the group, and also helped to facilitate participation. The following example is taken from the transcript of the mixed gender focus group:

Chelsea: So, like, with one of the articles that you guys brought up earlier, "I'm a fuckin' alcoholic" there are some swears and profanity in *Harsh Reality*. How do you feel about that?

Jim: There's really nothing wrong because growing up in Winnipeg you're gonna learn how to swear, you're gonna learn all about that type of stuff. It's, it's you hear those words everywhere you go. You hear fuck, shit, bitch, all that stuff. You hear all those words. But what's not right is if some guy goes up to a girl and starts calling her a bitch or a ho or a slut. Same with girls too, they shouldn't be calling themselves that. They're just putting themselves down basically.

Staff Person from Ndinawe: What about other people who haven't spoken as much?

Participant: Yeah, same with me too. I don't like it when stuff is candy coated. Like in school, I hate it when stuff is like candy coated and they're trying to make stuff sound nice. You know what I mean?

The staff person and I inviting individuals to participate seemed to be well-received, and some of the more quiet participants shared their opinions when directly asked.

At the conclusion of the focus group, lasting 45 minutes, the participants each received an honorarium, and Margaret drove the group back to Ndinawe.

4.2.2 Data collection for focus groups - female focus group: Context & dynamics.

The female focus group took place on Wednesday, June 9th, 2010 at 4:45 p.m. at Magnus Eliason Recreation Centre (MERC). When I arrived at MERC, a staff person took me to a multi-purpose room upstairs where the focus group would take place. The staff person informed me that she would stay downstairs near the entrance and direct the participants upstairs as they arrived. The staff person was familiar with the participants as she had recruited the female youth.

At the time that the focus group was to begin, no participants had arrived. The staff person phoned several of the girls and found that most of them were at one of the girl's residence. The staff person did not clarify if the girls had forgotten about the focus group, or if they had chosen not to come. The staff person explained that the girls were

on their way, would arrive shortly, and were excited to come and eat pizza. I informed the staff person that the girls were not having pizza (and was unclear as to where that idea originated), but clarified that the participants would receive a snack of juice boxes and cookies, and a $20 honorarium for participating.

Approximately 20 minutes later, 6 female participants arrived. The staff person did not clarify if additional participants had been recruited and did not attend, or if only 6 participants had been invited to participate. The participants and I sat around a circular table with the audio recorder in the centre. Margaret sat on the periphery of the group writing observations. From the outset, the mood of the female focus group was noticeably different than the mixed gender focus group. The participants were quieter and more reserved. In my opinion, the participants seemed more skeptical of both the focus group, and of me, than the previous group had been.

The recording of the female focus group took place in two sections. After explaining the focus group and obtaining consent for participation, I began to ask questions about the resource. Four of the 6 participants indicated that they had seen *Harsh Reality* for the first time earlier that day. Two of the 6 had seen *Harsh Reality* previously; however, it became apparent that none had read enough of the resource to be able to participate in answering the focus group questions (such as what elements of the resource did you like and what topics were missing from the resource). As a result, I stopped the focus group after approximately 5 minutes in order to provide the participants with approximately 15 minutes to look through the resource before resuming the recorded conversation.

During the course of the focus group, it became apparent that one of the participants, who will be referred to as Molly, appeared to be the target of exclusion and bullying from the other participants. Often, when Molly provided a verbal response, it was met with criticism or a negative comment from another member of the group. At times, Molly did not say anything and was still singled out. In particular, this was notable from a participant who will be referred to as Sarah. The following examples are taken from the transcript of the female focus group:

Example 1:

> Chelsea: Is there any information when you were looking through just now that you didn't know until you saw it in the book?
>
> Sarah: It was all new for her (referring to Molly, implying she didn't know anything).

Example 2:

> Chelsea: Do any of you have your own cell phone?
>
> Molly: Yeah.
>
> Sarah: No. I don't care. (directed at Molly) Just say no because you don't really have one.
>
> Chelsea: It's ok, but you have one that you can use sometimes?
>
> Molly: Yeah.

Example 3:

> Margaret: How often do you use the internet?
>
> Molly: About 10 minutes a day.
>
> Sarah: She's lying. She uses like an hour a day.

Throughout the focus group, I attempted to mitigate this dynamic by providing verbal positive reinforcement to Molly when she offered a response, trying to provide Molly with non-verbal support such as smiling and nodding, and by reminding the group that everyone's responses were welcome. I also attempted to address this dynamic by making some humorous comments in order to break the tension of the group. For example:

> Chelsea: And these were the pictures that went with the Research Round-Up articles. Did anyone see the giant zit picture? (holding up the picture in the book)
>
> Sarah: I'm looking at it right now.
>
> Other participants: Yes (4x participants).
>
> Chelsea: Anybody want to hang it up on their wall?

In my opinion, Sarah's attitude significantly influenced the willingness of the participants to actively engage in the focus group. For example, in the beginning of the focus group, Sarah was more willing to participate and share her feedback. However, approximately half-way through the focus group, Sarah's answers became more curt and seemed to have the goal of cutting off conversation instead of encouraging dialogue. I am not aware of what precipitated this change. A lot of this change in attitude was evident in Sarah's tone, which is difficult to accurately capture in a written transcript. The following excerpts provide examples of Sarah's comments:

Example 1:

> Chelsea: Are there other topics that should be included [in the resource]?
>
> Sarah: We already learned all of this in school.

Example 2:

Chelsea: Are there other ways the resource could be distributed?

Sarah: We just said it. You open it and you read it.

Example 3:

Chelsea: Are there any websites it would be good to link *Harsh Reality* to? What are some of the websites you go to?

Sarah: I don't really care… I don't care about anything *Harsh Reality*.

It was evident that the other participants valued Sarah's approval; therefore, when Sarah's attitude towards the focus group changed, other participants seemed to reflect this change by limiting their own participation and responses. During periodic intervals in the focus group, the female staff person who recruited the participants came and sat in the multi-purpose room and listened. However, when the staff person was listening to the focus group, contrary to the staff person in the mixed gender focus group, she did not help to encourage conversation or involve herself in the discussion. In my opinion, the group dynamic significantly contributed to the female focus group being the shortest in duration, lasting only 26 minutes, and the participants often requiring multiple prompts in order to answer a question.

Perhaps this dynamic of being less than cooperative within the focus group was a specific character trait of Sarah. Perhaps her lack of engagement was not a specific character trait, but the result of having an "off "day (maybe even a result of the pizza confusion). However, it is noteworthy that the group dynamic of the female focus group was significantly more "stand-offish" than the mixed gender or male focus group. In light of Haldenby and colleagues' assertion that the female subgroup of street-involved

youth is the most vulnerable, perhaps it is reasonable that it would be most difficult for an outsider to parachute in and develop a working relationship with a group of female street-involved youth (Haldenby et al., 2007). If this is the group which is most likely to be exploited, this may impact their ability to trust people – particularly people who aren't "like" them (from similar neighbourhoods, from similar circumstances, and the like). These reasons may have contributed to my difficulty in developing a rapport with this group.

4.2.3 Data collection for focus groups - male focus group: Context & dynamics.

The male focus group took place at Resource Assistance for Youth (RaY) on Thursday, June 10th, 2010 at 5:00 p.m. Through her knowledge of several staff members working at RaY, Margaret contacted the organization to arrange a date and time for the focus group. The staff at RaY then recruited participants who use RaY's services to participate in the focus group.

In my opinion, RaY was an excellent resource to use for getting in touch with street-involved youth. When Margaret and I arrived, staff at RaY had already arranged a variety of comfortable seating, such as chairs, couches, and ottomans into a circle. In addition to the usual snack of granola bars/cookies and juice that I provided for the focus groups, the RaY staff also provided a variety of healthy snacks such as different types of fruit and crackers. While I set up the audio recorder, staff at RaY expressed that there were more people interested in participating than just the 10 participants, and that many of the girls who use the services at RaY had also expressed interested in participating. I

thanked the staff person for this information, and explained that RaY would certainly be a location to consider for focus groups for future projects.

Within 10 minutes of the scheduled start time, all 10 participants arrived at RaY. While the focus group was in an open area, because it was after the regular hours of RaY, there were no other people or distractions in the area. All participants provided oral consent to participate in the focus group, and to have the conversation audio recorded.

The male focus group seemed friendly and most participants were eager to volunteer information. This willingness to participate likely influenced the duration of the focus group; the male focus group was the longest, lasting for 55 minutes. There were a few participants who were more reserved, but these participants seemed to participate more when their specific input was invited.

Similar to the mixed gender focus group, there was one participant who often jumped in to answer each question right away. This participant will be referred to as Dan. On a few occasions, Dan corrected one of the other participants. I attempted to try and manage these instances by offering alternative suggestions for the issue being corrected. The following example is taken from the transcript of the male focus group:

> Chelsea: Are there any topics that you guys saw and you thought 'Hey, I didn't see anything about this in there?' …
>
> Participant: I was just wondering because it would be cool if it had like a success story from somebody who was bi-polar or did suffer from depression but made it out of that. I mean like there's a lot of negativity in this book, there's a lot of

negative things and stuff. But I don't think there's enough good things too. Like people that have waded through the shit and got out of it.

Dan: Well, with bi-polar it's not something you can pull out of.

Participant: But I mean somebody that might have dealt with it in a good way. Like it'd be good to have that.

Dan: Well with bi-polar there's only a couple of ways of dealing with it. It's controlling how much sun and salt you get, medications, or controlling your lithium with medications, which is another addiction that can happen. Because lithium in extreme amounts creates euphoria.

Chelsea: So maybe a story of someone who was able to manage their bi-polar?

Participant: Yeah, it'd be cool to hear something like that.

In particular, the male focus group seemed very responsive to each other's comments. Often, one person's comment would trigger a comment from someone else, and the participants would build on each other's responses. The comments were respectful, even if the participants didn't necessarily agree. The following excerpt is one such example:

Participant: I think [*Harsh Reality*] could have been a little bit smaller because like people that want the information, like some of them don't want to carry stuff, don't want to be seen carrying around something like that.

Participant: Yeah, and being judged and stuff. So I would make it like pocket sized.

Participant: But it's hard to do that because there's lots of information in here and you can't really fit it into a pocket sized book though.

Participant: I think you could have made it a bit bigger. And well, for me the writing a bit bigger because I'm kind of going blind.

Participant: I think it was a good enough size for a book like this.

At the conclusion of the focus group, several of the participants expressed that they had enjoyed participating in the focus group. The following excerpt is one such example:

Dan: Yeah, I would just like to thank you guys for actually putting this kind of stuff out there (several people agree). I very rarely see an actual book about this kind of stuff (several people agree).

The mood of the focus group seemed very relaxed, and most of the participants hung around and talked during the distribution of honoraria. When I was leaving after the distribution of honoraria, several participants stopped me to thank me individually for facilitating the focus group.

4.3 Data Collection for Distributors: Context & Dynamics

While it was proposed that five distributor interviews would take place, due to repeated difficulty contacting the individuals involved in distribution, the number of interviews was reduced to three.

The following table summarizes the types of distributors who participated in the interviews:

Table 4.3 *Types of Distributors who Participated in Evaluation Interview*

	Formal distributor	Informal distributor	Distributor through position
Interview 1	X	X	
Interview 2	X	X	
Interview 3			X

As described previously, in interviews 1 & 2, the participants were both employed as formal distributors, in addition to distributing the resource to their personal network of friends and family outside of the scope of their employment (informal distributor).

To conduct these interviews, I met with each of the 3 individuals separately. It was difficult to schedule a meeting time with the first participant because he did not have regular access to a phone or to email. This meeting was facilitated by Margaret liaising between myself and the distributor until eventually a time for the interview could be scheduled. I met with the participant at Sunshine House to complete the interview.

The interview with the second participant was much easier to arrange. Via Margaret, I obtained the participant's email address. Based on the short turn-around time of responses, the participant appeared to have regular access to email. In addition, the participant provided me with her personal cell phone number, which was instrumental in arranging a time and place to meet. I met the second participant in a common area at the University of Winnipeg to complete the interview.

The interview with the third participant was also arranged via email and cell phone. I know the third participant through her work at a youth serving organization where *Harsh Reality* had been distributed. I contacted this participant via email to ask if

she would be interested in participating in an interview. Through email and subsequent phone calls, we arranged to meet at a Starbucks to complete the interview.

The interviews with the distributors lasted between 20 and 30 minutes in duration. All 3 participants were very willing to share about their participation in the distribution of *Harsh Reality*, and their perspectives about the value of the resource, and potential suggestions for future editions. Due to the public location of two of the interviews, I wrote notes rather than using the audio recorder as the interviewee was speaking. At the conclusion of the interview, I thanked the participant and distributed the $20 honoraria.

In addition to the 3 participants, Margaret provided me with contact information for several other people who had served as distributors. I contacted these individuals by voicemail and email without success in soliciting any responses.

4.4 Methods of Data Analyses for Individual Interviews

As discussed in Chapter 3, the individual interviews used a combination of quantitative and qualitative questions. The quantitative responses for questions were assigned codes and entered into an Access document. The following are some examples of quantitative questions, and the code that was assigned to specific responses (codes indicated in blue).

Question 4: What is your ethnic background?

Aboriginal/Metis/Inuit 00	European/Caucasian 01	African/Middle-Eastern 02	Asian/Indian 03

Question 6a: Did you read any of *Harsh Reality?*

Yes	No	Don't Know
01	00	77

Question 6b: If yes, how much did you read?

Whole Thing	About 1/2	About 1/4	Flipped Through
00	01	02	03

The following codes were used for all of the quantitative questions:

Don't Know	Researcher did not ask the question	Participant Declined to Answer
77	88	99

It is also noteworthy that if a participant provided an answer that was not one of the coded responses, a code for "other" was used and an anecdotal response was entered in the Access document. For example, multiple participants provided the response that they were of mixed ethnicity (such as being Jamaican-Chinese, or Aboriginal-Caucasian). In these cases, the code "04" was used for "other" and the response was recorded anecdotally.

Once all of the quantitative data were entered into the Access document, these data were used to calculate the proportion of participants who provided each answer. In order to make the large volume of quantitative data easier to understand, the proportion of participants who provided each answer was calculated and then entered into a Data Table in Word document. The Data Table allowed both gender stratified analysis, and cumulative analysis of all of the questions. The following is an example of a Data Table:

Table 4.4 *Data Table: Male & Female Individual Interview Participants' Method of Receiving Harsh Reality*

Methods for Receiving *Harsh Reality 4*	Male	Female	Subtotal # of Participants	Total # of Participants
Distributor	7	5	12	100
Health Centre	0	0	0	
Friend	3	3	6	
Drop-In Centre	17	4	21	
Other	3	3	6	
Evaluator	21	24	45	
Evaluator gave *HR 4*, but had seen previous editions	6	4	10	

Male "Other" Responses: B&L Resources, family, cousin,

Female "Other" Responses: "It came to me", brother, school.

To compile the qualitative responses from the individual interviews, a Word document was created. Each anecdotal response was recorded under its appropriate question. After entering all of the anecdotal responses into the Word document, each question was analyzed individually. This involved grouping similar responses together and then counting the frequency with which different themes appeared. The frequency of thematic responses was then compiled in an Excel spreadsheet. The spreadsheet also included a column where any relevant additional comments were recorded. The acronym "IQ" preceded all of the comments from the individual interviews. This was done because, at a later date, the comments from the focus groups would also be added to the spreadsheet and a method to determine the source of the comments was necessary. "IQ" was chosen to represent "Individual Questionnaire" (because "II" for "Individual

Interview" was too easily confused with the Roman numeral). The following is an excerpt of the Excel document for one qualitative question:

Table 4.5 *Example of Individual Interview Anecdotal Responses in an Excel Document*

Question 9: What do you like the most about *Harsh Reality*?

Topic	Individual Interview	Additional Comments
Gangs	x3	IQ "The info about gangs. It's not like the police tell you", "IQ "The gang stuff"
"Opens"/ "Non-Judgmental"	x4	IQ "It's down to earth, open and non-judgmental", IQ "It's open about how things are", IQ "It's very open about lots of things, like drugs", IQ "It makes sense with young people. It's a neutral position"
Story "I'm a fuckin' alcoholic"	x2	
Easy to Read	x4	IQ "It's easy to read, it makes you want to learn about stuff", IQ "It's an ok reading level", IQ "It's easy to read". IQ "It's easy reading"
Condom Use/ Safe sex	x3	IQ "All of it's pretty good, especially sex and safe sex", IQ "Stuff on using a condom…info about female condoms (but I've never used it)", IQ "The stuff about safe sex"
HIV/AIDS	x3	IQ "HIV testing centres"

The electronic Access, Word and Excel files were stored on a password protected computer in my locked office. Any hard copies of individual interviews, consent forms, or evaluation notes were stored in a locked filing cabinet within this same office.

4.5 Methods of Data Analyses for Focus Groups

Once all of the focus groups were completed, I transcribed each of the audio recordings into Word documents. Margaret's observation notes were also typed at the conclusion of each group's transcript. Following the transcription, in order to better facilitate comparison between the groups, the three separate transcripts were combined into one cumulative document. The same questions were used for each of the focus groups (although in some cases, the exact order of questions may have been slightly altered to reflect the direction of the group's conversation). In the cumulative document, for each question, the three groups' responses were copied from the individual transcripts and pasted under the relevant question. Each group's transcript was assigned a colour of text, and the groups' responses were colour coded in the cumulative document. An example of the format of the cumulative document is as follows:

Legend:

Green = mixed focus group

Red = female focus group

Blue = male focus group

> Chelsea: Does anyone know any places in Winnipeg where someone could go get tested for HIV?
>
> Participant: Mount Carmel Clinic.
>
> Participant: Mount Carmel, there's the Teen Clinic, there's the Health Sciences Centre.
>
> Participant: The hospital.
>
> Participant: Don't know. (x2)

Participant: Klinic.

Participant: Clinics.

Participant: Hospitals.

Participant: Walk-in Clinic.

Participant: Margaret. (x4)

Participant: Right here. (RaY)

Participant: 9 Circles.

Participant: K Klinic.

Participant: Siloam Mission.

After sorting all of the focus group responses into the cumulative document according to their question, these responses were added to the Excel spreadsheet used to organize the anecdotal responses from the individual interviews. The goal of combining all of this information into the spreadsheet was to help me view which responses were the most prevalent, and also to assist in determining if particular themes were more apt to arise in a particular gender of focus group. "Additional Comments" were preceded by one of the following codes to keep track of the data source for each comment:

MXFG = Mixed Gender Focus Group

FFG = Female Focus Group

MFG = Male Focus Group

IQ = Individual Interview/Individual Questionnaire

The following is an example of the spreadsheet containing both the individual interview and focus group responses:

Figure 4.3 Example of Excel document containing responses from individual interview and focus group participants

What were the parts you liked most in *Harsh Reality?*	MXFG	FFG	MFG	IQ	Additional Comments
Mental Disorders				x1	
Drug Harm Reduction				x3	IQ "Liked the info on needle cleansing"
Personal Stories		x3	x2	x10	
Poems				x6	IQ "I liked the poems"
Direct /Straight Forward			x7	x6	IQ "doesn't beat around the bush", MFG "It's like reality smack into your face, and that's what's good about it", MFG "It tells you straight up how things are", IQ "The information was straight up and understandable", IQ "This shows it exists. It is 'harsh reality'", IQ "easy to understand", MFG "The diseases and stuff you can get from using needles, stuff like that"

Upon completion of entering the focus group and individual interview data into the spreadsheet, the responses were tallied and answers were listed in order of the responses occurring with the most frequency descending to responses with the least frequency.

4.6 Method of Data Analysis for Distributors

Due to the small number of participants, it was very easy to compare the responses of the 3 distributors. Instead of typing transcripts of each of the interviews, I photocopied the pages of my notebook that contained the notes I had taken during each of the interviews. These individual pages (as opposed to pages bound in a notebook), enabled me to place the interview notes side-by-side and read each distributor's response to a particular question. This allowed me to view if there were any commonalities or themes between the three participants' responses. As I read through the responses, emerging themes and findings were written into my notebook. The notes based on reading the 3 participants' responses at the same time were then reviewed as the basis for the findings from the distributor interviews.

As with all other hard-copies of evaluation materials, distributor consent forms and all notes pertaining to the evaluation were stored in a locked filing cabinet in my locked home office.

Chapter Five – Data Analyses and Findings

5.1 Data Analyses and Findings for Individual Interviews

5.1.1 Data analyses and findings for individual interviews: Demographic information.

Table 5.1 *Data Table: Male & female Individual Interview Participants' Demographic Information*

	Male	Female	Subtotal # of participants	Total # of participants
Number of participants	58	42	100	100
Currently attending school	20	21	41	100
Not currently attending school	38	21	59	
14–17 years old	16	14	30	100
18–21 years old	19	14	33	
22–24 years old	23	14	37	
Aboriginal/Metis/ Inuit	25	20	45	100
European/Caucasian	26	12	38	
African/ Middle Eastern	0	1	1	
Asian/Indian	0	1	1	
Other – mixed ethnicity	4	5	9	
Other	3	3	6	

Male "Other - Mixed Ethnicity" Responses: Aboriginal & European, African & Asian, Native & Jamaican, Philippino & Cree

Female "Other – Mixed Ethnicity " Responses: Aboriginal & Inuit, European & Indian, German & Metis, Cree & African, Aboriginal & Ukranian

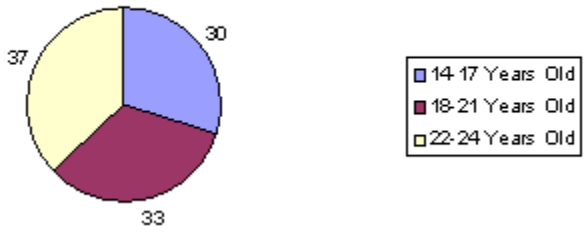
Male "Other" Responses: Jamaican, Canadian, "None"

Female "Other" Responses: Canadian, "nothing", "all ethnic groups"

For the individual interviews, there was a relatively even distribution of male to female participants with 58 males and 42 females.

All individual interview participants were in the target age range of 14-24. To assess the distribution of the participant ages within the range of 14-24, I created three categories: 14-17 years old, 18-21 years old, and 22-24 years old. The number of participants, both male and female, in each of these three age categories was determined to be approximately 1/3 of the total number of participants. The following graph represents the age distribution of participants:

Figure 5.1 Graph of male & female individual interview participants' age distribution

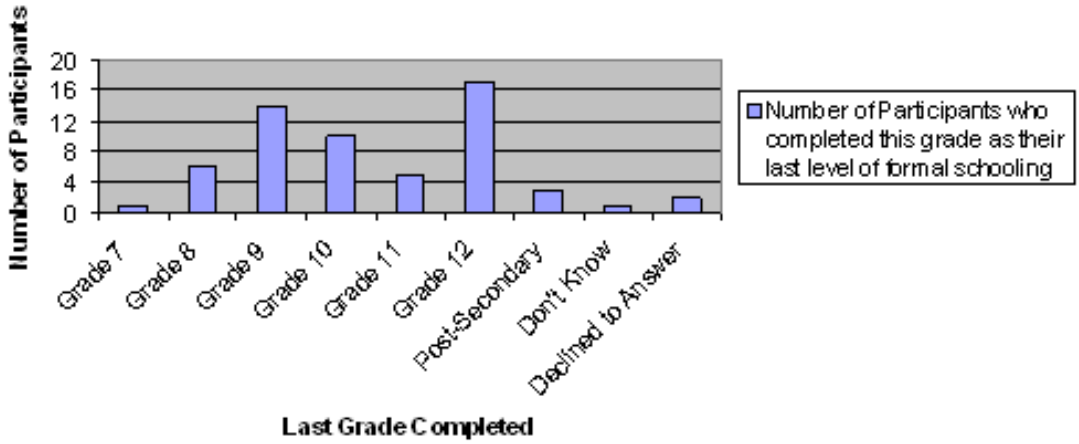


When stratifying the age data by gender, for the categories of 14-17 years old and 18-21 years old there are approximately the same number of male and female participants. However, in the 22-24 years old category, there were notably more male participants (23) than female participants (14). Overall, the age category with the most participants was 22-24 years old.

The majority of participants, 59, were not attending school at the time of the interview. The last grade completed for those not attending school ranged from grade 7 to post-secondary. Of those not attending school, 20 expressed that they had completed

grade 12 (3 of whom had also attempted some post-secondary education). The average last grade of school completed for those participants not attending school (excluding participants who declined to answer or did not know) was grade 10. The following graph illustrates the frequency of the last grade completed by participants not attending school.

Figure 5.2 Graph of last grade completed for male & female individual interview participants not currently attending school



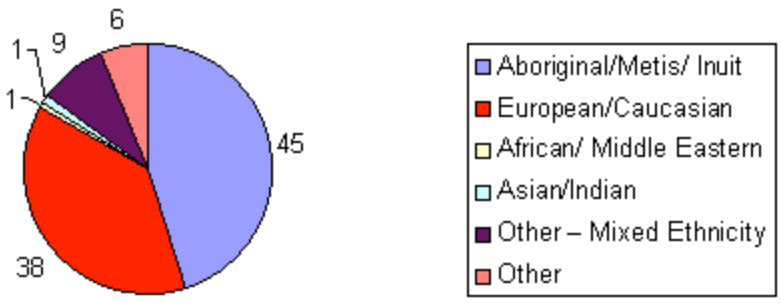
Of the 41 participants attending school at the time of the interview, the majority of participants (15) were attending grade 12.

Determining the ethnic background of participants proved to be a more challenging task than originally anticipated. The question as written in the individual interview reads, "What is your ethnic background?" However, many participants did not understand what "ethnic" meant. Often, a participant's response would be "Canadian". It was helpful to ask probing questions about the ethnicity or background (a better understood choice of words) of the participant's parents. However, despite an additional

explanation, some participants were still unable to identify their ethnic background. These participants are represented in the "other" category.

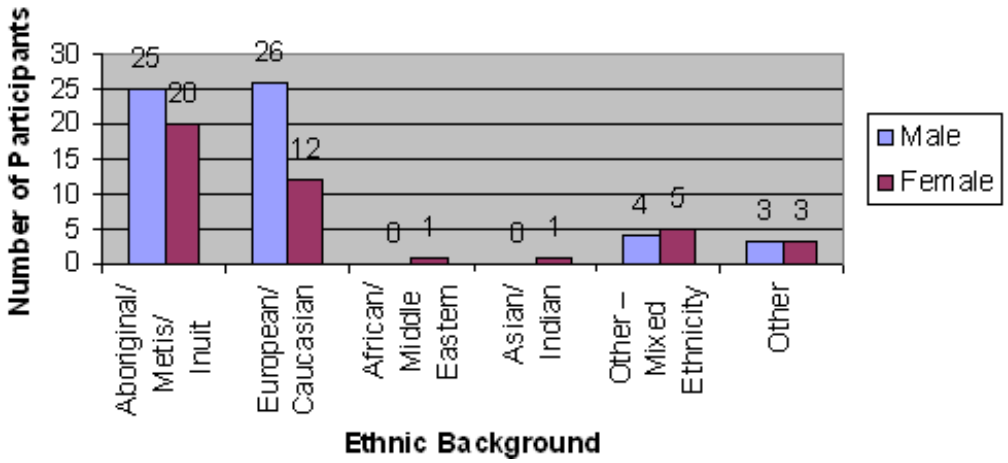
Another point of interest is that there were multiple participants who were of blended ethnic background. This necessitated the addition of a second "other" category, that of "other – mixed ethnicity". Participants in the "other – mixed ethnicity" category might have an ethnic background that combines two of the categories. One such example might be someone who has an Aboriginal father and a German mother. In total, 15 participants were included in the "other" and "other – mixed ethnicity" categories. The following graph represents the ethnic background distribution of individual interview participants:

Figure 5.3 Graph of male & female individual interview participants' ethnic backgrounds



The majority of ethnic background categories were represented approximately equally between the two genders. One exception was the European/Caucasian category, which had more than double the number of male participants than female participants. The following graph represents the distribution of ethnic background stratified by gender:

Figure 5.4 Graph of male & female individual interview participants' ethnic backgrounds: Gender stratified



5.1.2 Data analyses for individual interviews: Familiarity with Harsh Reality.

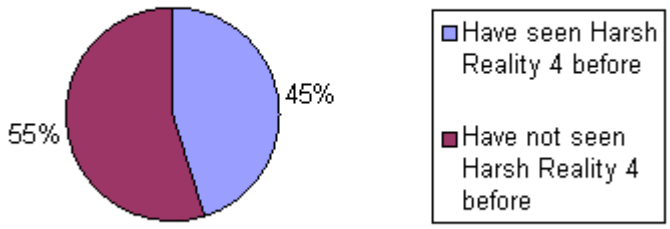
Table 5.2 *Data Table*: *Male & Female Individual Interview Participants' Familiarity with Harsh Reality*

	Male	Female	Subtotal # of Participants	Total # of Participants
Have seen *Harsh Reality 4* before	31	14	45	100
Have not seen *Harsh Reality 4* before	27	28	55	
Have seen *Harsh Reality 2* and/or *Harsh Reality 3* before	10	4	14	100
Have not seen *Harsh Reality 2* and/or *Harsh Reality 3* before	32	33	65 (+ 14 participants not asked, + 3 participants responding "I don't know")	

Following the demographic information, the individual interview questions intended to gauge participants' familiarity with *Harsh Reality*. Due to questions pertaining to previous editions of *Harsh Reality*, in this section, the most recent edition of *Harsh Reality* will be referred to as *Harsh Reality 4*.

In response to the question "Have you seen *Harsh Reality 4* before?" participants were approximately evenly divided between those who were familiar with the resource, and those who learned about the resource for the first time during the evaluation.

Figure 5.5 Graph of male & female individual interview participants' familiarity with *Harsh Reality 4*



However, when the genders were stratified, there was a notable difference between the number of male and the number of female participants familiar with the resource.

Figure 5.6 Graph of male individual interview participants' familiarity with *Harsh Reality 4*

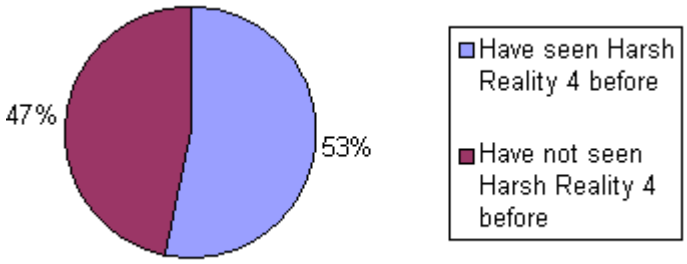
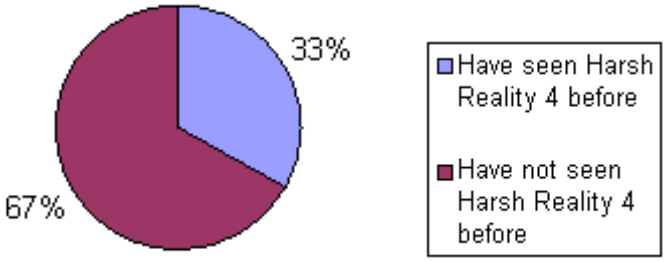


Figure 5.7 Graph of female individual interview participants' familiarity with *Harsh Reality 4*



More than half of the male participants expressed having previously seen the resource, while only one-third of the female participants reported having heard of or seen *Harsh Reality 4*. Fourteen of the participants (both genders) discussed having seen previous editions of *Harsh Reality (Harsh Reality 2* and/or *Harsh Reality 3)*.

Table 5.3 *Data Table: Male & Female Individual Interview Participants' Method of Receiving Harsh Reality*

Methods for Receiving *Harsh Reality 4*	Male	Female	Subtotal # of Participants	Total # of Participants
Distributor	7	5	12	100
Health Centre	0	0	0	
Friend	3	3	6	
Drop-In Centre	17	4	21	
Other	3	3	6	
Evaluator	21	24	45	
Evaluator gave *HR 4*, but had seen previous editions	6	4	10	

Male "Other" Responses: B&L Resources, family, cousin

Female "Other" Responses: "It came to me", brother, school.

There was an almost equal division between the number of participants who had received a copy of *Harsh Reality 4* prior to the evaluation (46), and participants who received a resource for the first time during the evaluation (45). In addition to the 45 participants who were introduced to *Harsh Reality* at the time of the interview, 9 participants received a resource from the evaluator but had already seen or heard of the resource. Of those who had already received a resource prior to the evaluation, the most common manner of receiving a copy had been through a drop-in centre (21), followed by receiving a copy from a distributor (12). The most common drop-in centre where participants accessed copies of *Harsh Reality 4* was at RaY. Six participants had seen *Harsh Reality 4* from a friend, and half of the 6 "other" responses described receiving the resource from a family member. No participants reported seeing or receiving a copy of *Harsh Reality 4* from a health centre.

Table 5.4 *Data Table: Male & Female Individual Interview Participants' Quantity of Harsh Reality Read*

Amount of *Harsh Reality* read	Male	Female	Subtotal # of Participants	Total # of Participants
Whole Thing	3	1	4	100
About 1/2	6	4	10	
About 1/4	8	7	15	
Flipped Through	40	29	69	
Declined to Answer	1	1	2	

All of the participants described that they had read at least some of *Harsh Reality*. The majority of participants, 69%, said they had "flipped through" the document. There were not any significant differences between the two genders in terms of participants who reported reading the whole resource, about half of the resource, or about ¼ of the resource.

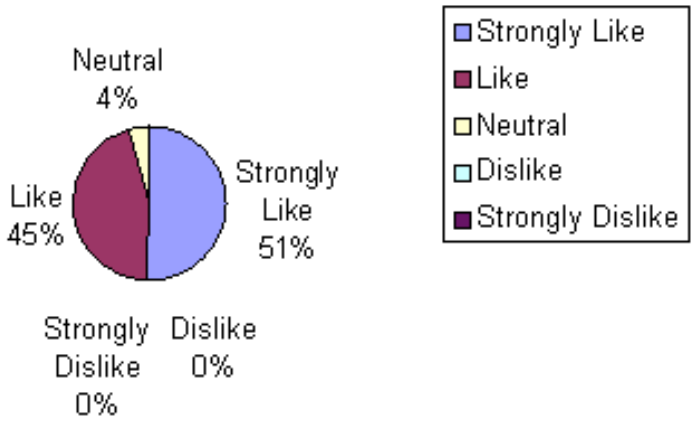
5.1.3 Data analyses for individual interviews: Perceptions of Harsh Reality.

Table 5.5 *Data Table: Male & Female Individual Interview Participants' Perceptions of Harsh Reality's Look*

What do you think of the look of *Harsh Reality*?	Male	Female	Subtotal # of Participants	Total # of Participants
Strongly Like	28	21	49	100
Like	27	17	44	
Neutral	2	2	4	
Dislike/Strongly Dislike	0	0	0	
Declined to Answer	1	2	3	

The response to the look of *Harsh Reality* was extremely positive. With the exception of 3 participants who declined to answer, the vast majority of participants selected the responses "strongly like" or "like" to describe their perception of the look and lay-out of the resource.

Figure 5.8 Graph of male and female individual interview participants' perception of the look of *Harsh Reality*



Both genders appeared to share similar responses to the look of *Harsh Reality*; approximately half of the male and female participants selected "strongly like" (48% of male participants, 50% of female participants). Both genders each had 2 participants who selected "neutral", and neither gender had any participants select "dislike" or "strongly dislike" as a response.

Table 5.6 *Data Table: Male & Female Individual Interview Participants' Perception of Harsh Reality's Value*

Do you think *Harsh Reality* contains information that is interesting and/or valuable?	Male	Female	Subtotal # of Participants	Total # of Participants
Yes	58	38	96	100
No	0	0	0	
Declined to Answer	0	4	4	

Another issue which received a strong positive response was in regards to the question "Do you think *Harsh Reality* contains information that is interesting or valuable?" While 4 participants declined to answer, a unanimous 100% of the participants who responded agreed that *Harsh Reality* does provide interesting and/or valuable information.

5.1.4 Data analyses for individual interviews: Research Round-Up articles.

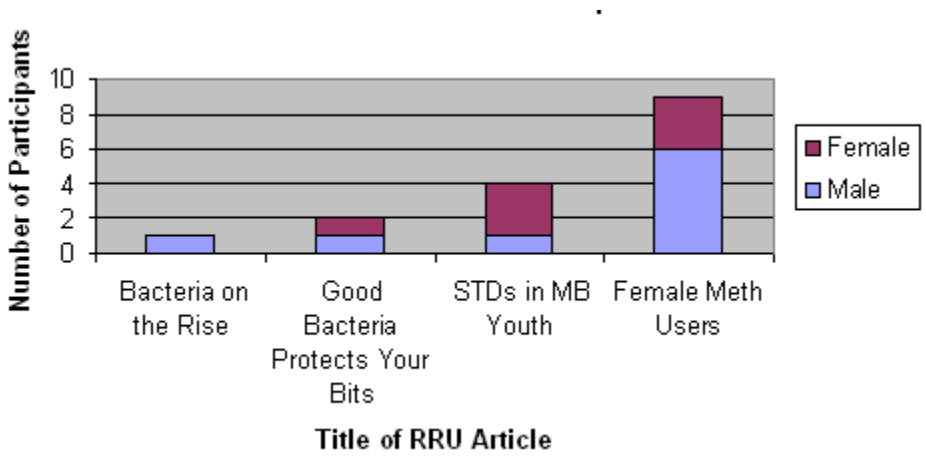
Table 5.7 *Data Table: Male & Female Individual Interview Participants' Familiarity with Research Round-Up Articles (including familiarity with title and picture prompts)*

Questions re: Research Round-Up Articles (RRU)	Responses	Male	Female	Subtotal # of Participants	Total # of Participants
Do you remember seeing/reading any RRU?	Yes	9	5	14	100
	No	43	35	78	
	Don't Know	1	0	1	
	Declined to Answer	5	2	7	
Distribution of "Yes" Responses					
	Yes – Bacteria on the Rise	1	0	1	* Will not add up to 14 because some participants recalled more than one RRU title
	Yes – Good Bacteria Protects Your Bits	1	1	2	
	Yes – STDs in MB Youth	1	3	4	
	Yes – Female Meth Users	6	3	9	
After seeing RRU titles, do you remember seeing/reading any RRU?	Yes	34	25	59	100
	No	16	12	28	
	Declined to Answer	8	5	13	
Distribution of "Yes" Responses	Yes – Bacteria on the Rise	14	5	19	* Will not add up to 59 because some participants recalled more than one RRU title
	Yes – Good Bacteria Protects Your Bits	4	5	9	
	Yes – STDs in MB…	15	13	28	

	Yes – Female Meth Users	19	14	33	
After seeing RRU pictures, do you remember seeing/reading any RRU?	Yes	39	31	70	100
	No	7	5	12	
	Declined to Answer	12	6	18	
Distribution of "Yes" Responses	Yes – Bacteria on the Rise	29	26	55	* Will not add up to 70 because some participants recalled more than one RRU title
	Yes – Good Bacteria Protects Your Bits	4	5	9	
	Yes – STDs in MB Youth	11	13	24	
	Yes – Female Meth Users	20	20	40	

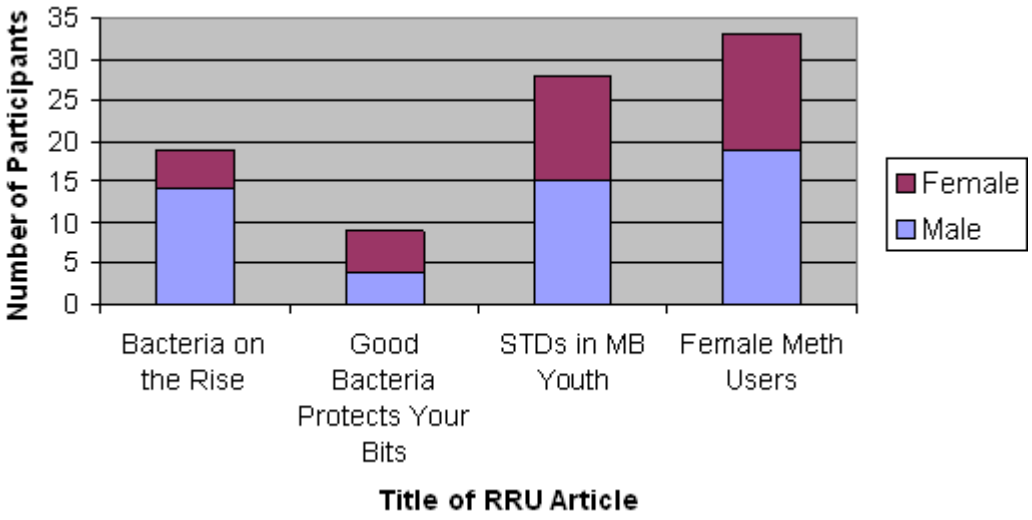
Initially, when asked if they remembered seeing or reading any Research Round-Up articles (RRU), 14 of the participants answered yes. The following graph illustrates which RRU titles were recalled in the absence of any prompts.

Figure 5.9 Graph of male & female individual interview participants' recall of Research Round-Up articles (no prompt)



However, with each additional prompt, more participants reported remembering Research Round-Up articles. When shown a list of the RRU titles as a prompt, the amount of participants who reported remembering Research Round-Up articles increased dramatically; from 14 participants to 59 (34 males and 25 females). Of these 59 participants who recognized the RRU titles, 22 expressed remembering two or more of the RRU articles, and 2 participants reported remembering all four articles.

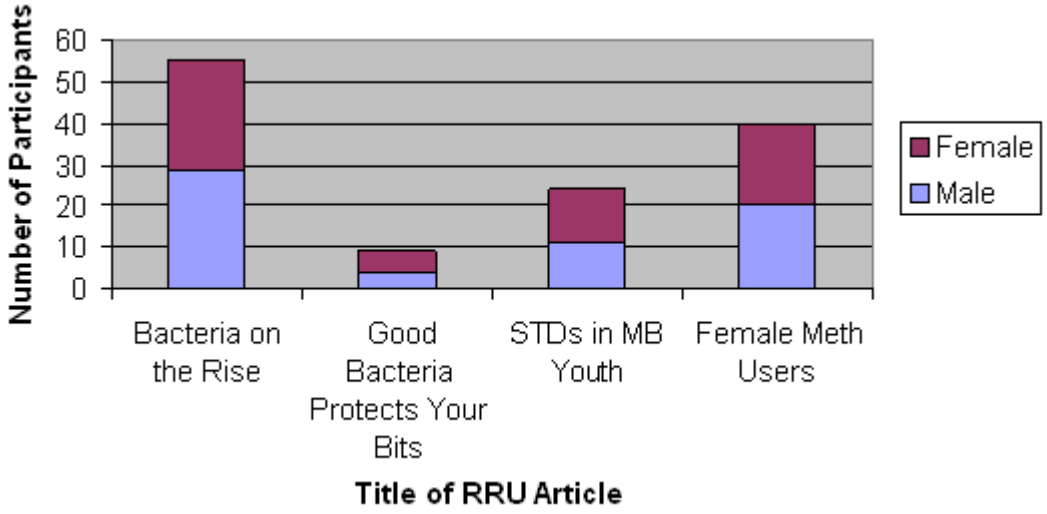
Figure 5.10 Graph of male & female individual interview participants' recognition of Research Round-Up articles based on title prompt



Generally speaking, the number of male and female participants who recognized 3 of the 4 RRU titles was approximately equal. The exception was for the article "Dangerous bacteria on the rise". For this article, approximately 3 times as many male participants as female participants recognized the title (14 male participants, 5 female participants).

After determining how many participants recognized the Research Round-Up articles as a result of seeing the titles, participants were shown the pictures from the four RRU and asked if they recognized any of the images. Again, the number of participants continued to increase. From the original 14 participants who recalled seeing or reading a RRU article, after viewing the corresponding images, the number of participants who recalled seeing a RRU grew to 70 (39 males, 31 females).

Figure 5.11 Graph of male & female individual interview participants' recognition of Research Round-Up articles based on picture prompt



It is interesting to note that the Research Round-Up articles with the "less scientific" images presented as more memorable than the articles with more "traditionally scientific" images (such as a map, or photos of bacteria under a microscope). The two most recognized RRU images incorporated shock value and humor: the picture of the giant pimple corresponded with "Dangerous bacteria on the rise", and "Female meth users" incorporated a modified Telus ad posing a multiple-choice question that asked how someone would choose to break up with their partner: via email, text, phone call, or chlamydia. Of additional note is that the only image incorporating colour (the giant pimple) was also ranked as the most memorable; all other RRU images were displayed in black and white.

5.1.5 Data analyses for individual interviews: Knowledge of HIV testing sites.

Table 5.8 *Data Table: Male & Female Individual Interview Participants' Knowledge of HIV Testing Sites*

Do you know anywhere you could go for an HIV test?	Male	Female	Subtotal # of Participants	Total # of Participants
Yes – 9 Circles	19	5	24	* Will not add up to 100 because some participants provided more than one HIV testing site
Yes – Family Doctor	16	15	31	
Yes - Other	31	26	57	
No	7	5	12	
Declined to Answer	0	1	1	

Female "Other" Responses:

Hospital x7 (2 specified Health Sciences Centre, 1 specified emergency room)
Clinic x6
Klinic x4
Walk in clinic x3
Mount Carmel x3
Teen Health Clinic
Sage House
Boyd Medical Centre
4 Rivers Medical Centre
Women's Clinic
RaY Clinic
Community Health Nurse
"Somewhere you don't know anyone"
"Look in the phone book"

Male "Other" Responses:

RaY Youth Clinic x6
4 Rivers Medical Centre x5
Walk-In Clinic x4
Klinic x4
Hospital x3 (including HSC)
Teen Clinic on Portage x2
A clinic x2
Sunshine House x2
Mount Carmel Clinic
High-Rise Broadway clinic)
Siloam Mission
Public Health Nurse
"Ask someone you trust"
"Look at *Harsh Reality* for a resource page"

When asked to identify sites where one could go for HIV testing, 12 participants responded that they did not know any sites of HIV testing in Winnipeg (7 males, 5 females). Twenty-four participants expressed that testing is available at 9 Circles. Nine Circles is the testing location most frequently referenced in the article "HIV testing: Old stuff/new stuff". However, it bears mention that male participants were 4 times more likely to provide this response than female participants (19 male participants, 5 female participants).

Thirty-one participants (16 male, 15 female) answered that one could go to a family doctor for HIV testing. This is not a testing site that is explicitly suggested in *Harsh Reality*. The most popular response to this question was "other", in which participants suggested an additional location for HIV testing. Often, participants suggested multiple testing locations. The following list outlines the "other" responses suggested by both male and female participants. The list is ordered from most frequent response to least frequent response for each gender. The red text highlights testing locations present in both genders' lists.

Table 5.9 *"Other" HIV Testing Sites from Male & Female Individual Interview Participants*

Male "Other" Responses	Female "Other" Responses
RaY Youth Clinic x6	Hospital x7 (2 specified Health Sciences Centre, 1 specified emergency room)
Four Rivers Medical Centre x5	Clinic x6
Klinic x4	Klinic x4
Walk-In Clinic x4	Walk-in Clinic x3
Hospital x3 (1 specified Health Sciences Centre)	Mount Carmel Clinic x3
Teen Health Clinic x2	Teen Health Clinic
Sunshine House x2	Sage House
Clinic x2	Boyd Medical Centre
Mount Carmel Clinic	Four Rivers Medical Centre
High Rise Broadway Clinic	Women's Clinic
Siloam Mission	RaY Youth Clinic
Public Health Nurse	Community Health Nurse
"Ask someone you trust"	"Somewhere you don't know anyone"
"Look at HR for a resource page"	Look in the phone book

* The red responses occur in both gender groups.

While many of the "other" responses are present in both the female and male lists, it is uncommon for responses to appear with the same frequency in both lists. For example, although the RaY Youth Clinic is the most popular "other" response for males (6 participants), it is one of the least popular "other" responses for females (1 participant). Similarly, Four Rivers Medical Centre is the second most popular "other" response for males (5 participants), while only 1 female participant listed this location. Seeking testing at a hospital was a response present in both lists; however, it was the most common "other" response for female participants (7 participants), while only cited by 3 male participants. Klinic and Walk-In Clinics received a similar number of responses, 4 and 3 respectively, from both genders. This data suggests that perhaps, different gender are more familiar or more comfortable accessing different service providers.

Only 1 participant (male), who was able to name a testing site in Winnipeg, cited *Harsh Reality* as his source for that information.

5.1.6 Data analyses for individual interviews: Knowledge of types of HIV tests.

Table 5.10 *Data Table: Male & Female Individual Interview Participants' Knowledge of the Four Types of HIV Tests*

Do you know the names of the different HIV tests?	Male	Female	Subtotal # of Participants	Total # of Participants
Yes – Name Based/Nominal	0	2	2	102 **
Yes – Coded/ Non-Nominal	0	0	0	
Yes – Anonymous	1	0	1	
Yes – Rapid Test/ Point of Care Test	4	1	5	
Yes – Other	13	5	18	
No	41	31	72	
Declined to Answer	1	3	4	

Male "Other" Responses:
Bloodwork/ "the blood one" x3
Chlamydia x2
Pap Smear
HIV/Hep C test
HIV Positive
Gonorrhea
Urine
STD Test
"The new one"
Unspecified
* Note: There are more responses than number of male participants that said "other" because several participants suggested multiple "other" methods of testing

Female "Other" Responses:
Pap Smear/Pap Test x3
Blood Test x3
Herpes
Chlamydia
Gonorrhea
Pee Test
STD

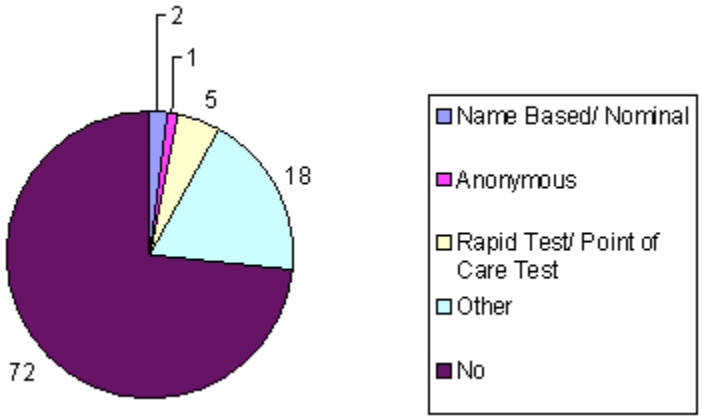
* Note: There are more responses than number of female participants that said "other" because several participants suggested multiple "other" methods of testing

** Note: The total is "102" instead of "100" because two participants provided multiple answers. One participant knew of both rapid testing and an "other" method. A different participant knew of both rapid testing and anonymous testing.

This data speaks to one of the principal guiding research questions that aims to measure specific knowledge uptake. Within *Harsh Reality*, the information about the different types of HIV testing is available in the 3 page article "HIV testing: Old stuff/new stuff". The article provides details about the four different types of HIV tests currently available in Winnipeg (with additional information about testing sites in Brandon): Name-Based/ Nominal testing, Coded/ Non-Nominal Testing, Anonymous Testing, and Rapid Testing/Point of Care Testing.

During the individual interview, the majority of participants, 72, said that they did not know any of the different types of HIV tests available. Analyzed by gender, approximately the same number of male and female participants did not know the different types of HIV tests (71% of male participants, 74% of female participants). The following graph illustrates the distribution of responses for both genders in regards to types of HIV test knowledge. Due to no participants providing the response "Coded/Non-Nominal testing", this type of test was omitted from the graph.

Figure 5.12 Graph of male & female individual interview participant's knowledge of different HIV tests



For the "other" responses, 18 participants shared methods they thought were conducive to testing for HIV. The most popular response that arose in both genders was "blood test". While not one of the specific four types of HIV test described in *Harsh Reality*, all four types of tests are blood tests. Therefore, this response shows that, although not familiar with the specific names of HIV tests listed in *Harsh Reality*, these participants are familiar with what type of test is necessary to check for HIV.

The majority of "other" responses provided by participants would not be appropriate to test for HIV. After "blood test", the second most common "other" HIV testing method provided was "pap smear/pap test" (1 male participant, 3 female participants). Both groups also had participants who provided the "other" responses: Chlamydia, gonorrhea, and "pee test".

Of the types of tests described in *Harsh Reality,* the test that was best known to participants was the Rapid Test/Point of Care Test (4 male participants, 1 female participant). The second most common response was Name Based/Nominal Testing (1

male participant, 2 female participants), followed by Anonymous testing (1 male participant).

One male participant was able to provide the names of two types of HIV testing described in *Harsh Reality*: Rapid Testing and Anonymous Testing. However, when asked how he learned about these types of testing, the participant responded that he didn't know how he had learned the information. Of the additional 4 participants who were familiar with Rapid Testing, 2 also did not know how they had learned about that type of test, and 2 participants knew about Rapid Tests because they had undergone the test.

5.2 Data Analyses for Focus Groups

5.2.1 Data analyses for focus groups: Familiarity with Harsh Reality.

In general, with the exception of the participants in the female focus group, the focus group participants expressed having seen *Harsh Reality 4* (the most current edition) prior to the day of the focus group. For the male and mixed gender focus groups, the majority of participants expressed having been introduced to *Harsh Reality 4* via the institution used to recruit their participation (Ndinawe and RaY). No participants expressed that they were given a copy by resource centre staff. Rather, the majority of male and mixed gender participants described that they had come across a copy of *Harsh Reality 4* that was "lying around" and either took it home, or read it at the community resource centre. Two participants (one from the mixed gender focus group and one from the male focus group) reported seeing *Harsh Reality 4* while in jail (the name of the correctional facility was not specified).

In the female focus group, as previously described, 4 of the 6 participants saw *Harsh Reality* for the first time on the day of the evaluation. However, those 4 participants clarified that they had received a copy *Harsh Reality* earlier in the day (and therefore were not introduced to the resource for the very first time during the focus group).

Two of the mixed gender focus group participants reported being familiar with *Harsh Reality 3*, one describing seeing a copy at Ndinawe, the other seeing a copy at a high school. Four of the male focus group participants expressed they had seen three versions of the resource: *Harsh Reality 2, Harsh Reality 3, and Harsh Reality 4*. Most of these participants cited RaY as the location for seeing these resources, with one expressing that he had seen all three versions "in different jails".

5.2.2 *Data analyses for focus groups: Research Round-Up articles.*

Following the same procedure as with the individual interviews, focus group participants were first asked if they remembered seeing or reading any Research Round-Up articles (RRU) with no prompts, then shown a list of the four titles, and finally shown the four corresponding images. While each participant in the group was not asked this question individually, the transcript of oral responses, in addition to Margaret's written notes and my own notes, created a general picture of the participants familiarity with the RRU articles.

In response to the initial question about seeing or reading any Research Round-Up articles, the general consensus was that participants did not remember the articles. No one recalled seeing a RRU in either the mixed gender nor the female focus group. In

the male focus group, two of the participants were unsure, one responding "I think so" and the other saying that the term Research Round-Up "rings a bell". However, neither participant was able to describe any information contained in any of the Research Round-Up articles.

Upon seeing the list of titles, more participants expressed that they had seen a Research Round-Up article. Three participants in the mixed gender focus group explained that they remembered the "Female meth users" article, as did 3 participants in the male focus group and 1 participant in the female focus group.

After viewing the titles, in the female focus group, 2 participants expressed remembering seeing the "STDs in Manitoba street youth" article, and another participant expressed recognizing the titles from the table of contents (but explained she did not look at the actual articles). The "Dangerous bacteria on the rise" article was recalled by one male focus group participant. No participants expressed remembering the RRU article "Good bacteria protects your bits".

Following the same trend as the individual interviews, the RRU images were the most effective prompt at reminding participants if they had seen a Research Round-Up article. In the mixed gender focus group, at least half of the participants (5) expressed seeing the picture of the pimple that goes with the "Dangerous bacteria on the rise" article. As a follow-up question, I asked the people who remembered the pimple if they had read the article or just looked at the picture. One participant responded that the picture was "too gross" to stay on the page so he did not read it, and at least 3 other participants agreed with his rationale. Four people in the mixed gender focus group remembered seeing the image of the Telus ad that corresponded with the "Female meth

users" article. Again, when asked if any of those who recognized the image had read the article, one participant responded "I just looked at the picture and read that, not the article." Two of the mixed gender focus group participants said they recognized the map that goes with the "STDs in Manitoba youth" article, but did not read the article.

As a follow-up question, the mixed gender focus group was asked why they think people did not tend to read the Research Round-Up articles. The following are some of the participant responses from the mixed gender focus group transcript:

Participant: I didn't want to look at the picture (the zit).

Participant: Sometimes [the RRU] were long. It seemed like they were a bit long and some of the words were big.

Participant: Yeah, 'cause some people can't read big words.

Participant: 'Cause like for me, they might look at it and see a big word and be like 'huh, what does that mean?'

In the female focus group, the Research Round-Up questions were asked when the dynamic of the group was at one of its least responsive times. Therefore, soliciting responses from the participants was a challenge. Five of the participants remembered seeing the pimple picture for "Dangerous bacteria on the rise". Two participants recalled seeing the Telus ad with the "Female meth users" article, and 2 participants remembered the map of Manitoba for the "STDs in Manitoba youth" article. Three of the participants expressed that they remembered seeing the picture of bacteria under a microscope as featured with the "Good bacteria protects your bits" article.

In the male focus group, one participant expressed he had seen all four of the pictures. Two participants recognized the Telus ad for the "Female meth users" article.

For the articles "Good bacteria protects your bits" and "STDs in Manitoba street youth", most participants (approximately 7) said that they had seen each of the respective pictures. This is in contrast to the results from the individual interviews, in which few participants reported viewing the pictures for "Good bacteria protects your bits".

As a follow-up question to the discussion of Research Round-Up articles, participants in the male and female focus groups were asked if they thought it was a good idea for *Harsh Reality* to include information about research that is happening in Manitoba. The participants in the female focus group thought it was a fine idea, but seemed rather ambivalent:

> Chelsea: Do you think it's a good idea that the book has information about research that's happening in Manitoba?
>
> Participant: Kinda. Because it makes Manitoba not look dumb (laughs).
>
> Participant: Oh yeah, Manitoba's not dumb.
>
> Participant: It's good so that they'll know more stuff.

On the other hand, the male focus group had several participants who appeared to feel strongly about the importance of including information about recent research in Manitoba. The following are some examples from the male focus group transcript:

> Chelsea: Do you think in general people want to know about research that's happening with young people in Manitoba?
>
> Participant: You don't have a choice. You have to know what's going on…
>
> Participant: I think a lot of people do, actually.
>
> Participant: I think a lot of people in the city should be more aware of what's going on in the street instead of listening to the media demonize everything…

Participant: They'd come to find out if they looked through a book like this. This has probably saved my dick in many ways.

Whether expressed in an ambivalent or emphatic manner, the general consensus of focus group participants is that there is value in sharing information about recent research in Manitoba, particularly recent research with the street-involved population.

5.2.3 Data analyses for focus groups: Perceptions of Harsh Reality.

Echoing the sentiments from the participants in the individual interviews, the focus group participants had a positive opinion of the look and lay-out of *Harsh Reality*. All three groups indicated that they liked the graffiti-style graphics included throughout the resource and on the cover. All three groups also indicated that they liked that there were many pictures and images included throughout the document. During the focus groups, this question tended to be a jumping-off point for participants to begin talking about other themes (notably, what topics were missing from *Harsh Reality*). In general, as themes emerged during the discussions in the focus groups, I allowed the conversation to follow those themes. As a result, there is not a large amount of focus group data regarding participants' perceptions of the look of *Harsh Reality.*

5.2.4 Data analyses for focus groups: Knowledge of HIV testing sites.

When the three groups were asked if they were aware of any sites in Winnipeg that offer HIV tests, participants tended to respond individually instead of speaking at the same time. These types of individual responses were conducive for creating a spreadsheet to view how often each response was given.

Table 5.11 *HIV Testing Sites suggested by Focus Group Participants*

Do you know any sites for HIV testing?	Mixed Focus Group	Female Focus Group	Male Focus Group
Yes (unspecified)	x1		
Mount Carmel Clinic	x2		
Teen Clinic	x1		x1
Hospital	x2	x2	
School Nurse	x1		
Don't Know	x2		
Ndinawe	x1		
North End Wellness Centre	x1		
North End Y	x1		
Ralph Brown	x1		
Klinic		x1	x1
Clinics		x1	x1
Teen Talk		x1	
Walk-In Clinic		x1	
Margaret			x3
RaY			x2
9 Circles			x1
Siloam Mission			x1
Sunhine House			x1
Doctor's office			x1
Addictions Foundation Manitoba			x1

As is evident in the table, the two most common responses were to be tested at the hospital (4 participants), followed by 3 participants suggesting being tested by Margaret (who often performs rapid tests as part of ongoing research).

In general, the list of possible testing sites provided by the focus group participants is quite close to the list provided by the individual interview participants. The testing sites that appear on both lists are: Mount Carmel Clinic, Teen Clinic, the

hospital, Klinic, clinics, Walk-In Clinic, Public Health Nurse/Margaret, RaY, 9 Circles, Sunshine House and Doctor's Office.

5.2.5 Data analyses for focus groups: Knowledge of types of HIV tests.

Again, for this question participants tended to speak individually. Therefore, when transcribing the recorded conversation, it was possible to count individual responses and display the data in a spreadsheet. The following table outlines the three focus groups' responses:

Table 5.12 *Knowledge of Types of HIV Tests in Focus Group Participants*

Types of HIV tests	Mixed Focus Group	Female Focus Group	Male Focus Group
Blood test	x1	x1	
"Pee test"	x2	x1	
Rapid HIV tests			x2
"normal one"			x4
"the one with the needle"	x1		

Similarly to the individual interview responses to this question, very few participants were able to name one of the four types of HIV tests described in *Harsh Reality*. The 2 male focus group participants who were familiar with rapid tests both cited personal experience undergoing the test as the reason they were familiar with that method of HIV testing. The misconception that a urine test can identify if someone is HIV positive or negative surfaced in 2 of the 3 focus groups. Again, as identified by some of the individual interview participants, 2 focus group participants identified that a

blood test is necessary to test for HIV. While this is true, a generic "blood test" was not one of the specific test types outlined in the "HIV testing: Old stuff/new stuff" article.

5.2.6 Data analyses for focus groups: Emergent themes.

During the course of the focus groups, several strong themes emerged. This was particularly apparent in regards to suggestions of topics to include in future editions. All three focus groups noted that it would be beneficial to include information about prescription drugs in future resources. This suggestion also came up in the individual interviews, but not with the prevalence found in the focus groups. I was surprised at how many specific prescription drugs participants made reference to during the three focus groups. The following table summarizes the drugs which were mentioned by name in each group:

Table 5.13 *Prescription Drugs Referenced by Focus Group Participants*

Name of Drug	Male	Female	Mixed
Prescription Drugs	x	x	x
Benzodiazepine	x		
Ritalin	x		
Dexagrin	x		
Respirol	x		
Syroquil	x		
Xanax *			x
Lorazepam*			x
Purcocet		x	x
Oxycontin		x	

* Type of Benzodiazepine

The following excerpts from the respective focus group transcripts further illustrate the participants' substantial knowledge of prescription drugs, and their desire to see more of this theme represented in possible future editions of *Harsh Reality*.

Excerpt from male focus group:

Participant: Benzos are a big one too because if you're taking benzos for a long period of time you could die.

Participant: I heard pharmacy drugs are a big problem now too.

Participant: Yeah, like Ritalin is a huge one, Dexagrin.

Participant: I used to take Dexagrin.

Participant: Respirol.

Participant: I've never been on Syroquil.

Participant: I have. Holy.

Participant: Like a lot of the narcotic ones that are sleepers, a lot of those are really bad.

Excerpt from mixed focus group:

Participant: There's nothing in [*Harsh Reality*] about pills…

Chelsea: So let's talk about drugs for a second. What are some of the drugs that you hear about people doing that they need some more information about?…

Participant: Pills.

Chelsea: What kind of pills?

Participant: Xanax.

Partcipant: Prescription pills.

Participant: Ecstasy.

Participant: Lorazepams.

Participant: There's a lot of prescription pills that people could get high off of. I remember this one time I was at a party and this guy popped a Lorazepam, I think, into my drink. And I never want to feel that again, that's all I got to say.

Excerpt from female focus group:

Chelsea: When you were going through *Harsh Reality* was there anything that you didn't like?

Participant: I think they should put more info on prescribed drugs. Like narcotics you can get from the doctor that are supposed to help you.

Participant: Like Oxycontin, Purcocet that kind of stuff.

Chelsea: Any other topics people thought were missing?

Participant: I don't know. Pretty much all of it's in there.

Participant: I think it's there other than the pills part (several people agree).

Building upon the theme of prescription pills, one participant in the male focus group described a type of party, a "pharmaparty", that is predicated upon the use of prescription drugs. As he described, at a pharmaparty "you just put your hand in a bowl of pills and then take a shot of whiskey and yeah, make a cocktail." This type of activity could have obvious implications and risks, such as combining prescription drugs with alcohol, mixing different prescription drugs, and of course, the risk of ingesting unknown substances. The topic of prescription drugs is certainly one theme that emerged as one of the most prevalent in the evaluation.

A second theme that arose in both the mixed gender focus group and the male focus group was the topic of diabetes. In the male focus group of ten participants, two

people discussed that they had diabetes, and another expressed that he was affected personally by diabetes in his family.

Excerpt from male focus group:

> Participant: I looked through [the section on] diabetes. I just got diagnosed. Nobody in my family has it. A lot of things in here have some good information, like what to eat and what not to eat…
>
> Participant: I looked in the table of contents because my whole family has diabetes. I had a couple of family members who died of diabetes…
>
> Participant: I just read a little bit just by skimming through, trying to find things that related to me and my life situation. And uh, I guess I did stop off on diabetes because I have it as well. But I've had diabetes for quite some years so I know how to live with it already.

Excerpt from mixed focus group:

> Chelsea: And in terms of Sexually Transmitted Infections, are there any in particular you guys hear about and you think 'ok people for sure need information about this STI'?
>
> Participant: AIDS.
>
> Participant: Chlamydia.
>
> Participant: Diabetes? (people laugh)
>
> Chelsea explains that diabetes is not an STI but it's an important topic.
>
> Participant: Yeah, diabetes. That's a really good idea.
>
> Margaret: Why do you think diabetes is important?

Participant: 'Cause it's like what you eat and how it will affect you and what happens to your body.

Participant: So people know what to eat.

Participant: So that people don't get overweight.

Particularly in the mixed gender focus group, the topic of nutrition and the importance of knowledge regarding nutrition and healthy food choices came up several times. Concern was expressed by one of the participants that access to fresh fruits and vegetables can be a challenge for people living in the North End or living downtown. One participant suggested that future editions of *Harsh Reality* might include examples of healthy recipes that could be made with ingredients commonly found at convenience stores or corner stores.

The law came up briefly in the male focus group, but seemed to be a larger theme in the mixed focus group. Concerns about the law did not arise in the female focus group. In particular, the theme of the law in the mixed gender focus group seemed to revolve around police behaviour and concerns about law enforcement's treatment of Aboriginal people. The following is an excerpt from the mixed gender focus group:

Participant: What about cop brutality? What I mean is that there are some cops out there that will take you, take you out to the perimeter highway, beat the shit out of you and make you walk home. That type of brutality.

Chelsea: So you'd like people's stories who have experienced that?

Participant: Yeah, like stories. 'Cause that's pretty harsh. Like, they're supposed to be protecting, how can I put this…they're supposed to be protecting

their own people, basically. But there's cops out there that are racist. Yet we're not, like as a human race we're not supposed to be racist…

Participant: Yeah, because I've seen a police officer beat up a native guy for no reason. He wasn't resisting, he wasn't nothing. Yeah, he was getting arrested but he wasn't resisting. They beat him with batons and they tazed him. And like how the cops are tazing little 14 year old kids out here and stuff like that. It's like, it's making me think what's this world coming to man?...

Participant: Like it's happened, it's happened to me where they've actually shocked me in the back of my leg with a tazer and it hurts (laughs). I've never felt a pain like that in my life until then.

Existing information about the police and the law was cited by both the male focus group and the mixed gender focus groups as elements of *Harsh Reality* that they liked the most. As outlined in the preceding excerpt, in addition to information about the law, the topic of police brutality was one of the most popular topics suggested by the mixed gender focus group to be included in future editions of *Harsh Reality*.

Another theme that was raised in both the male and mixed gender focus groups was the issue of prostitution. Again, this topic did not surface in the female focus group. However, it is interesting that neither group addressed male prostitution in Winnipeg. Rather, males expressed their concern about young girls becoming involved in the sex trade.

Excerpt from male focus group:

Participant: One thing I did notice that [*Harsh Reality*] was missing was how there is a growing population of young girls that are prostituting themselves (multiple people agree).

Participant: I know a few girls that just live with a guy, like a really not hygienic guy, like I'm not gonna say who they are but I know a few people who are like that. And these guys are really, like they're dirty, they don't take care of themselves, they leave dirty needles around, crack pipes, and all that. And there'll be a young, smart, good looking girl that'll live with the guy just to get high all the time. And that's like uh, that's like selling yourselves for sex but, like you said, there's a lot more of that going on now.

Excerpt from mixed gender focus group

Participant: Or the bosses out there that get their little girls and they let them smoke some crack (one person agrees) and they get all fiended out and they say 'hey I've got some custies here that will pay for you to suck 'em off" or something. Shit like that happens all the time.

Participant: Yeah (agrees).

Participant: It's sickening.

Based on the conversations in the focus groups, it appeared that all references to females in the sex trade were tied closely to addiction issues, and the need to earn money in order to purchase drugs.

One topic which came up during the discussion of prostitution and then continued to surface during the male focus group was the issue of hygiene. However, even after reviewing the transcript multiple times, it is still not clear what the term

"hygiene" means to the participants: if they are referring to hygiene in a traditional sense of the word (such as having a clean body, brushing your teeth, and the like) or if hygiene refers to avoiding people who are "dirty" such as people who have an STI or use drugs. There seems to be a co-mingling between protective measures, such as using a condom, and being hygienic, such as having a clean body. For some participants, there also seemed to be the thought that being unhygienic (as in unclean) could facilitate the transmission of, or even cause, an STI.

Excerpt from male focus group:

> Participant: Actually one thing I just realized I didn't see much of in [*Harsh Reality*] was information about personal hygiene (multiple people agree). Like hygiene on the street, or you know, after sex…And uh, it would be nice to see that in here because I'm seeing more and more of the people who would get their hands on this, addicts, youth that are on the street, that are using drugs, that are sexually active, I see a lot of them stopping to care about themselves enough to take care of their own hygiene and bodies.
>
> Participant: There isn't really anything in there about hygiene, really. Except for just like, I don't know, like use protection (several people agree).
>
> Margaret: So is the thought that things are dirty?
>
> Participant: Well, when you're sexually active or you're doing drugs, anything that comes into contact with your skin, your blood, if you're using a condom, a diaphragm, it doesn't matter. Even if somebody's going bareback, it's different every time. And if a girl doesn't wash herself she can get herself a kidney infection or a bladder infection.

Participant: Or an STI.

Participant: If she's dirty and you sleep with her, like if she hasn't showered and washed herself with soap, showered, bathed, whatever, you know, cleaned her body entirely it can give the guy a urethral infection, a bladder infection, and then a kidney infection if it's left long enough.

Participant: Or an STI (multiple people say).

Particularly in light of the strong interest expressed in this topic by the male focus group, the issue of hygiene and how it connects (and does not connect) with sexually transmitted infections could be a very engaging and valuable topic to explore in future resources.

One theme that was a recurring topic of conversation during the mixed gender focus group was that of gangs. Of interest is that, even though the majority of participants in the mixed gender focus group were male, the topic of gangs did not arise as an important issue for participants in the male focus group. Mixed gender focus group participants highlighted that it was good that *Harsh Reality* contains information about gangs, but indicated they would like to see even more attention given to this topic in the future, particularly the pressures to become involved in a gang. The following are excerpts from the mixed gender focus group transcript:

Participant: There should be more gang stuff (multiple people agree)…

Chelsea: When you guys are talking about 'gang stuff', do you mean like what are the different gangs, or more like people's experiences in a gang?

Participant: Yeah, yeah people's experiences (multiple people agree)…

Participant: All the gangs push on you is like, they push this idea on you like –

Chelsea: So kind of about the pressures?

Participant: Yeah, pressures. Like them pressuring you to get in or get down.

Participant: And if you don't they'll kill you.

Participant: Yeah, they'll kill you…

Participant: They keep doing it and doing it and doing it. And when they're doing that to you and puttin' pressure on you, you don't want to, like some people will take it to the limit and be like 'fuck life bye bye' and do it to themselves. Like they'll kill themselves. I've seen it happen.

The mixed gender focus group also brought up the topic of females in gangs and expressed that more information about girl gangs would also be beneficial.

During the focus groups, another theme that was suggested to include in future editions of *Harsh Reality* is more information about what to do in the event of someone overdosing. While there is a significant amount of information in *Harsh Reality* about different types of drugs and drug use, there is currently no information about how to react if someone has overdosed. The absence of this information may be because the best thing to do if someone has overdosed is to call 911 instead of attempting to help the person yourself. However, due to the clandestine nature of drug use, if the fear of getting caught using illegal substances impedes someone's desire to call 911, it may be worthwhile to include information about how to help someone who is overdosing as a harm reduction strategy.

Further, participants expressed that one of the results of being in the proximity to someone who has overdosed was not necessarily a question of "What can I do to help the person?", but rather an opportunity to share how scary the situation was. The intense

emotions involved in watching someone overdose or blackout appeared to be a topic that multiple participants could relate to, as evidenced in the following excerpts from the male focus group:

> Participant: [*Harsh Reality*] should have some information about how people are when they're overdosing (multiple people agree).
>
> Participant: Yeah, I don't think there's anything in there about that.
>
> Participant: Is there stuff about blackouts in here?...There's nothing about what overdosing looks like. I've seen someone overdose in front of me. I kept her alive until the paramedics got there. It's scary man (several people agree). It was so scary. And, it's not something I like to remember.
>
> Participant: Yeah. It's hard to describe it. All I was able to do when a buddy of mine od'd on heroin was sit there and watch him do the chicken. And then all of a sudden he stopped and [was] gone.
>
> Participant: That's different than what I seen. Like when she overdosed she just nodded out. Like she nodded out and then fell forward and then she kept falling forward. I asked her if she was ok and she said 'Yeah I'm ok.' And then I went to go do whatever I was gonna do and she kept falling forward, and then all of a sudden she smack and hit the floor. And then her lips were purple, her eyes were purple…and her fingertips, and she was white all over. She wasn't doing the chicken or whatever like seizuring. She was just dead. And then, yeah, I didn't know what to do. Like I read certain pamphlets and stuff that said what to do when somebody od's, but I didn't remember. I just called 911. But I saved her life, that's what they told me anyway.

In general, the perspectives and opinions shared by focus group participants provided an excellent supplement to the data obtained from the individual interviews. The ability to engage in more detailed conversation, and for a longer period of time, helped to provide a fuller picture of the context of the participants' life experiences, and a more-developed sense of their perceptions of *Harsh Reality*.

5.3 Data Analyses for Distributors

Both of the formal distributors who participated in an interview had been involved in the youth working group that created the newest edition *Harsh Reality*. Both explained that they became involved in the working group and subsequent distribution through their contact with Margaret (from previous work Margaret has done in Winnipeg). Both expressed that it was "a lot of work" to put *Harsh Reality* together, and described feeling a sense of pride at their involvement in the project.

Both formal distributors expressed that they had enjoyed participating in the distribution of the resource, and in the mapping activity that had preceded distribution. For the mapping activity, distributors walked around Winnipeg in order to better understand where youth congregated. Based on the information from this mapping activity, the distribution routes for *Harsh Reality* were developed. Both formal distributors expressed that it was a good idea to walk around and hand out books directly to youth, as opposed to leaving them at a community resource centre. In addition to their paid hours as formal distributors, both of these participants took additional copies of *Harsh Reality* to distribute to their personal network of friends and family.

When asked what advice they might provide for a new distributor, one of the formal distributors shared that it would be beneficial to pair that new person with someone who is either familiar with the geographic neighbourhood, or has participated in distribution previously. As she pointed out, pairing a less experienced distributor with a more experienced distributor allows the new distributor to benefit from his partner's knowledge about potential areas (or people) to avoid, and also mitigates the risk of becoming lost in an unfamiliar neighbourhood. Both distributors highlighted that it was a good idea for at least one of the people in the team of two distributors to be carrying a cell phone.

When asked to describe challenges involved in distribution, both formal distributors described that it can be challenging to transport multiple copies of *Harsh Reality* while walking because the books are heavy. One participant expressed that she tried to manage the weight of the resources by using a bag with wheels that could be pulled. However, the weight of the books could pose a limitation in that distributors could only take out a maximum of approximately 20–25 books at a time (depending on their personal strength, and the method of transporting the resources).

The distributor through position was not able to speak to personal experience walking around and handing out the resource. However, this participant did express that she thought the method of going out into the community was an "innovative" and "effective" method of getting *Harsh Reality* into the hands of the intended audience. The distributor through position explained that she tended to leave copies of *Harsh Reality* in common areas of the community resource centre where she works. This way the books would be accessible to youth using the services of the organization. Locations included

the coffee table in the waiting room and the bookshelf in the multi-purpose room. Copies of *Harsh Reality* were also made available to community resource centre staff on the tables in the lunchroom, and on the bookshelf in the multi-purpose room. The participant described that although she did not give copies of *Harsh Reality* to youth and explicitly encourage the youth to take a copy home, the copies in the waiting room kept "wandering off". She concluded that youth were accessing the resource and taking copies. The distributor through position indicated that she thought *Harsh Reality* was a valuable resource, and would be willing to distribute future resources through the community resource centre where she is employed.

Chapter Six – Summary and Conclusions

6.1 Focus Groups and Individual Interviews: Overarching Themes

In general, participants in both the focus groups and the individual interviews had positive perceptions of *Harsh Reality.* The element of *Harsh Reality* most frequently described as something the participants liked was the inclusion of personal stories (highlighted in all three focus groups, and in 17 individual interviews). In particular, the stories specifically mentioned by name were: "Growing up with bi-polar parents" (individual interviews x5), "I'm a fuckin' alcoholic" (individual interviews x2, female focus group x2), "Mind fuck" (mixed focus group x1), and "Rehab stories" (individual interview x1). The general sentiment was that participants liked reading about topics that were more personal than articles based on statistics and facts. One individual interview participant stated, "[*Harsh Reality*] shares other teens' experiences in personal stories". An additional value of the inclusion of personal stories is that the issues described are taken out of the hypothetical, and described as real experiences. As one individual interview participant explained, "the personal stories and scenarios make [*Harsh Reality*] personalized. It really has happened". It seems that information carries more weight when there is a person's story attached to it, as opposed to impersonal facts that can be more easily dismissed.

While not as popular as the personal stories, poems also arose as a component of *Harsh Reality* that participants liked (individual interviews x6, female focus group x1), notably the poem "Peace" (individual interview x1, female focus group x1).

Participants' connection with the personal stories and poems written by individuals with similar life experiences is congruent with the literature reviewed in

Chapter 2. As described earlier, many street-involved youth have experienced a tumultuous home life and, either by being kicked out or choosing to leave, have ended up on the street. As Haldenby and colleagues discovered during their study of street-involved youth, "the resulting sense of betrayal and abandonment at the family…level led to deeper connections with individuals who shared similar experiences" (2007, p.1238). In the same study, participants described that the relationships formed between street-involved youth felt "more 'real', as they could empathize with one another and talk about their situations without feeling that they were being judged negatively" (Haldenby et al., 2007, p.1238). Rotheram-Borus and colleagues also describe the significant role of peers, and suggest that "peer relationships and perceptions of peers also appear to have a significant impact on youth's protective behaviours and should be a target of prevention programs" (Rotheram-Borus et al., 2000, p.18). McIntyre's study *Under the radar* also discussed the value of male sex trade workers learning from peer's experiences (2007).

This ability to relate to the authors of *Harsh Reality* as peers was one aspect of the resource that resonated most strongly with participants. As one male focus group participant expressed, when reading *Harsh Reality*, it made him feel like there was "somebody sitting there telling the story to your face rather than reading it." Feeling as if the information was provided by a peer and "not just a doctor's point of view" (male focus group participant) facilitated information sharing about topics that might be difficult to address for fear of negative judgment (such as sexual activity and substance use).

A second element that resonated very strongly with participants was the artwork included throughout *Harsh Reality*. While multiple participants commented on their affinity for the mix of various types of art (diagrams, drawings, charts, photos), the artwork grounded in graffiti tended to be particularly well-received. One individual interview participant described that she liked that *Harsh Reality* is so "art oriented". Another spoke of how art was very important in the resource because, describing street-involved kids in general, "We're all pretty artistic".

It also seemed to matter to participants that most of the images were not randomly placed, but often supported the information in nearby text. One individual interview participant pointed out "I liked that most pictures have something to do with what the page is talking about". In this regard, graphics not only add visual appeal and interest, but can also aid in the comprehension of text. This could be beneficial for individuals who may have a low reading level, or could be beneficial to supplement to articles written at a higher reading level.

Incorporating strategies to address the literacy level of street-involved youth is an important consideration when developing resources for this population. Based on the findings from this evaluation and also the results from the *Enhanced surveillance of sexually transmitted diseases among Winnipeg street-involved youth study* (Manitoba Health, 2004), at least half of the street-involved participants in each Winnipeg-based study were not currently attending school. While all participants in this study reported that they were able to read, it is reasonable to deduce that individuals who drop out of school will have a lower reading level than individuals who continue to pursue their education. Therefore, any means that could enhance the comprehension of material for

youth with a lower reading level, such as the inclusion of many images and graphics, can be very beneficial.

While I had anticipated that the personal stories and artwork would be positively received, I was surprised to discover that the volume of information and details provided in *Harsh Reality* would be perceived as equally important to participants as the inclusion of artwork. The same number of individual interview participants that expressed liking the informative and detailed nature of *Harsh Reality* also expressed liking the artwork (17). One individual interview participant described that *Harsh Reality* is "power-packed with info" while another expressed that he liked that *Harsh Reality* "gives a lot of information. It kind of helps." Participants in the mixed and male focus groups also commented favorably about the breadth of information included in *Harsh Reality*. In light of the finding that most individual interview participants "flipped through" the resource (69%), it appears that participants valued *Harsh Reality* more as a resource that they could browse through for relevant information, as opposed to using it as a book to read cover-to-cover.

The direct manner of sharing information used throughout *Harsh Reality* was also important to participants. This theme was brought up particularly in the male focus group (x7) and the individual interviews (x10). The term commonly used to describe the nature of *Harsh Reality*, particularly in the male focus group, was "straight-up". One male focus group participant described that *Harsh Reality* "is like reality smack into your face, and that's what's good about it". Another male focus group participant pointed out that "the information was straight-up" and that made it "understandable". The ability to share information in a candid and forthright manner appealed to the

participants as "honest". The value of this approach can be summarized by one individual interview participant: "It's how we live. It's true, and we can relate."

One of the characteristics of *Harsh Reality* that was referenced to explain why the resource was "straight-up" was the use of language. The inclusion of slang and profanity was well-received by the majority of individual interview and focus group participants. In light of the importance of peer relationships, it appeared that the use of this type of language helped to reinforce the perception that the authors of the resource were "like" the participants.

In addition to reflecting the normative language used by participants, multiple individual interview and focus group participants described that the use of profanity throughout *Harsh Reality* was "funny". A number of participants also described that, while they liked the use of such language, they were surprised by it. As one male focus group participants described "it was just two words that really shocked me out of the whole thing. On page 176 it said "Mind fuck"…and I said 'this is really a smack in the face." The novelty of a sexual health resource that incorporated more shocking language than other existing resources seemed to be appreciated by the target audience.

As previously described, there were several elements of *Harsh Reality* that, across the board, individual interview and focus group participants tended to appreciate (such as the personal stories). However, of interest is that some of the topics highlighted by a number of participants as the parts of *Harsh Reality* that they liked the most were the same topics highlighted by other participants as the parts of *Harsh Reality* they disliked the most. The following table summarizes the topics that were shared as participants' favourite and least favourite components of the resource:

Table 6.1 *Participants' Favourite and Least Favourite Elements of Harsh Reality*

Topic	What were the parts of *Harsh Reality* that you liked?	What were the parts of *Harsh Reality* that you did not like?
Drugs – General Information	1 x Female Focus Group 3 x Male Focus Group 9 x Individual Interview	1 x Female Focus Group 1 x Individual Interview (Concerns over not enough drug information, and particularly not enough information about prescription drugs)
STDs/ STIs	12 x Individual Interview	1 x Individual Interview (Concerns that this section was "fear mongering")
Cover artwork	6 x Individual Interviews	2 x Individual Interviews
Picture of the Zit	2 x Male Focus Group 4 x Individual Interview	4 x Mixed Focus Group 2 x Male Focus Group 2 x Individual Interview (Concerns that it was "really gross")
Drugs – Harm Reduction	4 x Individual Interview	4 x Individual Interview (Concerns that this section was encouraging drug use)
Gangs	1 x Male Focus Group 3 x Individual Interviews	4 x Individual Interview (Concerns this may entice someone to join a gang, other concerns that it was not relevant)
Artwork	1 x Mixed Focus Group 17 x Individual Interviews	2 x Individual Interviews (Concerns that there were not enough pictures)
Language	2 x Individual Interviews	2 x Individual Interviews (Concerns that language was too hard to read)

Of particular interest are the topics that some participants disliked because they feared that learning about these topics might encourage readers to participate in the described activities. This concern was raised specifically in regards to information about gangs and harm reduction information about drugs. The following are participant comments concerning these two topics:

Question: What were the parts of *Harsh Reality* you disliked?

Individual Interview: The drug thing maybe if it makes kids start.

Individual Interview: Condoning injecting heroin…everything else was alright.

Individual Interview: At first I thought the needle thing was bad.

Individual Interview: Is the goal to stop doing drugs, or to protect you if you are doing drugs? [*Harsh Reality*] should be more targeted to mainstream.

Individual Interview: I don't care for the gang stuff. It's not relevant.

Individual Interview: I don't like the gang stuff. Some might be enticed by it.

In Chapter 2, criticisms of the harm reduction approach were explained in detail. Often, critics of harm reduction fail to see a distinction between providing information about a behaviour and endorsing the behaviour (Brown & Horowitz, 1993). Addressing this distinction, and dispelling misconceptions about how access to information equates with encouraging behaviour was a recurring theme throughout the literature review (Marr, 2007; Valenti, 2009; Whiteside, 2008). In the context of this evaluation, it was interesting to see that skepticism of the harm reduction approach is not a belief held by "old people" alone (which is how some harm reduction advocates paint their objectors: very conservative old people). The comments from *Harsh Reality* participants show that even teenagers and young adults can have the perception that sharing information using a harm reduction approach may be detrimental if it incites participation in a "harmful" activity ("harmful" is in quotation marks because some activities, such as sexual activity, may not be viewed by most people as "harmful" in the same way that other activities, such as injection drug use, may be viewed).

6.2 Readability of Harsh Reality

"In Xanadu did Kubla Khan
A stately Pleasure-Dome decree:
Where Alph, the sacred river ran
Through caverns measureless to man
Down to a sunless sea".

- from "Kubla Khan" by Samuel Taylor Coleridge (1797)

6.2.1 Readability of Harsh Reality: Methods of assessing readability.

In order to assess the readability of *Harsh Reality*, three methods were used: the Passive Sentences Readability Score, the Flesch-Kincaid Readability Score, and the Flesch Reading Ease Readability Score. These three methods were chosen because, in addition to being the most popular methods I came across when consulting colleagues and searching for various methods, they are the methods used to determine readability of a document in Microsoft Word.

The Passive Sentences Readability Score provides "the ratio of passive sentences over active sentences" (RFP Evaluation Centers, 2011, Passive Sentences Readability Score section, ¶ 1). A passive sentence can be defined as a sentence that includes the following characteristics: a form of the passive auxiliary "be" (be/been/is/are/was/were), followed by a verb containing a past form (such as "ed" or an irregular past form) (RFP Evaluation Centers, 2011, How to find out whether a sentence is passive or active section, ¶ 2). The following examples illustrate a passive sentence and an active sentence sharing the same information:

Passive Sentence: The man was bitten by the giraffe.

Active Sentence: The giraffe bit the man.

The more passive sentences in a document, the more difficult the document is to read and understand (RFP Evaluation Centers, 2011, Passive Sentences Readability Score section, ¶ 1). In order to calculate the Passive Sentences Readability Score, the following formula is used:

Passive Sentences Score = (# of Passive Sentences/ # of Active Sentences) x 100

The RFP Evaluation Centre, a Canadian evaluation service based out of Quebec, clarifies that passive sentences should not be banned. However, they advise aiming for "a passive sentences score not equal to but close to 0" (RFP Evaluation Centers, 2011, Does it mean you need to ban passive sentences section, ¶ 1). The Passive Sentences Score can be lowered by avoiding using a passive sentence whenever it can be replaced by its active version (RFP Evaluation Centers, 2011, Does it mean you need to ban passive sentences section, ¶ 1).

The Flesch-Kincaid Grade Level Readability Score ranks the readability of text based on standard American grade-school level competencies. To do this, the Flesch-Kincaid Readability Score considers the average number of syllables per word and words per sentence (RFP Evaluation Centers, 2011, Flesch-Kincaid Readability Score, ¶ 1). In order to calculate the Flesch-Kincaid Grade Level Readability Score (FKRS), the following formula is used:

FKRS = (0.39 x ASL) + (11.8 x ASW) – 15.59

ASL = average sentence length in words (number of words divided by the number of sentences)

ASW = average number of syllables per word (the number of syllables divided by the number of words)

Based on this formula, a score of 5.0 means that someone in the fifth grade would understand the text, a score of 6.4 means someone who is slightly above a sixth grade level would understand the text, and the like. Usually, standard writing is between a seventh and eighth grade level; therefore most writing for the general public should "aim for a Flesch-Kincaid score between 7.0 and 8.0" (RFP Evaluation Centers, 2011, Flesch-Kincaid Reading Ease Readability Score section , ¶ 1).

Lastly, sections of *Harsh Reality* were assessed for readability using the Flesch Reading Ease Readability Score (FRS). This score rates text on a 100-point scale; "the higher the Flesch Reading Ease score, the easier it is to understand the document" (RFP Evaluation Centers, 2011, Flesch Reading Ease Readability Score section,¶ 1). In this case, most standard documents for the general public aim for a Flesch Reading Ease score of 60 to 70 (RFP Evaluation Centers, 2011, Flesch Reading Ease Readability Score section,¶ 1).

The Flesch Reading Ease Readability Score (FRE) is calculated using the following formula:

FRE = 206.835 – (1.015 x ASL) – (84.6 x ASW)

ASL = average sentence length in words (number of words divided by the number of sentences)

ASW = average number of syllables per word (the number of syllables divided by the number of words).

Once the Flesch Reading Ease Readability Score is determined, the score can determine the readability of a text based on the following classifications:

Figure 6.1 Flesch Reading Ease Readability Score chart

Flesch Reading Ease Score	Readability Classification
Score of 0 - 29	Very difficult to read
Score of 30 – 49	Difficult to read
Score of 50 - 59	Fairly difficult to read
Score of 60 - 69	Standard reading level
Score of 70 - 79	Fairly easy to read
Score of 80 - 89	Easy to read
Score of 90 - 100	Very easy to read

(Based on RFP Evaluation Centers, 2011, Flesch Reading Ease Formula section,¶ 3)

6.2.2 Readability of Harsh Reality: *Components of Harsh Reality assessed.*

The goal of assessing the readability of the entire document of *Harsh Reality* is outside of the scope of this evaluation. Therefore, I selected three key components to assess:

- The Research Round-Up articles
- The Article: "HIV testing: Old stuff/ new stuff"
- A selection of the personal stories

The Research Round-Up articles and the article about HIV testing were chosen because they represent 2 of the 3 specific learning outcomes examined in this evaluation. The third specific learning outcome, HIV testing sites in Winnipeg, does not have a corresponding article (instead, information about testing sites is available in the resource lists at the back of *Harsh Reality*, and some information about testing sites is included in the article "HIV testing: Old stuff/ new stuff").

A selection of personal stories was chosen in response to the positive reaction that both focus group and individual interview participants expressed regarding these texts. I was interested to determine if the selections that were more popular to read were the selections that were also easier to read. In total, there are 20 personal stories included in *Harsh Reality*. I chose to evaluate five of these stories, selected at random, to provide a general snapshot of the readability of the personal stories. To do this, I assigned each story a number between 1 and 20. Then, using a random number generator, five numbers between 1 and 20 were selected. The five stories corresponding to these numbers were used to assess the general readability of the personal stories in *Harsh Reality*.

In order to apply the Passive Sentences Readability Score, the Flesch-Kincaid Readability Score, and the Flesch Reading Ease Readability Score in Microsoft Word, it was first necessary to retype all of the articles I wished to assess as Word documents. In recopying the documents, care was taken to exactly replicate the spelling and punctuation used *Harsh Reality (*particularly since two of the three scores rely on sentence length and syllables per word).

The subsequent chart identifies the genre of each of the texts assessed, in addition to their length and three readability scores:

Table 6.2 *Summary Chart of Harsh Reality Readability Scores*

Title of Text	Genre	Word Count	Passive Sentences (Easiest Reading = score close to 0)	Flesch Reading Ease (Easiest Reading = score close to 100)	Flesch Reading Ease Level Based on Score	Flesch-Kincaid Readability Score (Score = grade level that would understand the text)
Dangerous bacteria on the rise	Research Round-Up	539	16%	46.3	Difficult	10.9
Good bacteria protect your bits	Research Round-Up	395	29%	48.1	Difficult	10.4
STDs in Winnipeg street youth	Research Round-Up	824	21%	56.9	Fairly Difficult	11.5
Female Caucasian meth users most likely to share needles	Research Round-Up	247	6%	74.0	Fairly Easy	6.4
HIV testing: Old stuff/new stuff	Article	913	45%	54.1	Fairly Difficult	9.5
Comastate subconscious	Personal Story	832	2%	78.2	Fairly Easy	7.0
Life with AIDS: An in-depth interview	Personal Story	1742	8%	74.9	Fairly Easy	6.9
I'm A fuckin' alcoholic	Personal Story	1430	4%	72.2	Fairly Easy	7.2
Sleep is for the weak	Personal Story	1159	2%	75.6	Fairly Easy	6.5
My story	Personal Story	1452	13%	79.5	Easy	5.3

6.2.3 Readability of Harsh Reality: *Analysis of readability based on Passive Sentences Readability Score.*

Based on the Passive Sentences Readability Score, the article that was the most difficult to read out of the articles assessed was "HIV testing: Old stuff/new stuff" (45% PSR). The two articles that were the easiest to read are "Sleep is for the weak" and "Comastate subconscious" (each with 2% PSR). Other articles that also had a relatively low PSR of under 10% were "Female Caucasian youth most likely to share needles" (6%), "Life with AIDS: An in depth interview" (8%), and "I'm a fuckin' alcoholic" (4%). In general, the Research Round-Up articles presented with a higher PSR score (average of 18%) than the personal stories (average of 5.8%).

6.2.4 Readability of Harsh Reality: *Analysis of readability based on Flesch Reading Ease Score.*

Based on this scale, 3 of the 4 Research Round-Up articles were "difficult" or "fairly difficult" to read, while the fourth, "Female Caucasian meth users most likely to share needles" was classified as "fairly easy" to read (of note, this is also the Research Round-Up article with the lowest Passive Sentence rating). The "HIV testing" article was also ranked as "fairly difficult" to read.

In contrast, the 5 personal stories were all fairly easy or easy to read (scores ranged between 72.2 – 79.5), with the easiest to read being "My story" with a score of 79.5 (interestingly, this text had the least favorable Passive Sentence rating of the personal stories with the highest score of the five: 13%).

6.2.5 Readability of Harsh Reality: *Analysis of readability based on the Flesch-Kincaid Readability Score*

The articles that were assessed displayed a wide range of grade level suitability, from fifth grade to between eleventh and twelfth grade. The Flesch-Kincaid Readability Score (FKRS) of the five personal stories was largely on target with proposed general readability level of between 7.0 and 8.0. Based on this scale, the easiest personal story to read was "My story" (5.3) and the most difficult was "I'm a fuckin' alcoholic" (7.2).

The Research Round-Up article "Female Caucasian meth users most likely to share needles" again scored as the easiest article of this genre to read, with a score of 6.4 – within the proposed guidelines for general readability. The other Research Round-Up articles all scored significantly higher, between a grade 10 and 11 reading level. Based on this scale, "STDs in Manitoba street youth" was the most difficult Research Round-Up article to read with a score of 11.5.

The "HIV testing" article also scored well above the general reading level. With a FKRS of 9.5, this article was slightly easier to read than 2 of the 3 Research Round-Up articles, but still quite a bit harder to read than all of the personal stories.

6.2.6 Readability of Harsh Reality: *Cumulative analysis of readability.*

In general, based on these three assessment tools, the personal stories do present as easier to read than the Research Round-Up and "HIV testing" article. However, it would be remiss not to point out that just because something is "easier to read" does not necessarily mean it is "easier to understand". For example, according to these evaluations, the personal story "Comastate subconsious" scores well: A 2% Passive

Sentences Score, A Flesch Reading Score categorizing it as "fairly easy" to read, and a Flesch-Kincaid Score placing it within a grade 7 reading level. However, I found this text very challenging to follow.

Reading "Comastate subconsious" reminded me of an English course I took in first-year University. We were assigned to read and interpret the poem "Kubla Khan" by Samuel Taylor Coleridge. After pouring over the text and trying to make sense of the pleasure-domes and sacred rivers, our professor eventually explained that the poem had been written by Coleridge when he was high as a kite on opiates. "Kubla Khan" was Coleridge's attempt to recapture the hallucinations and fantasies he had experienced in his drug-induced state.

Clearly, these readability scales were not developed to assess substance users' written streams of consciousness. But, in my opinion, this becomes another example of how these kids' stories don't exactly fit into mainstream society. Sure, their stories may incorporate active sentences and shy away from polysyllabic words – but just because the text might be "easy to read" or written at a grade 7 reading level, does not mean it is easy to comprehend. Take, for example, this excerpt from "Comastate subconscious":

> I KICK MY SOUL IN THE FACE AND PUSH IT DOWN AND BACK WITH AS MUCH FORCE like a curb stomp AS IF IT were TEETH THEY WOULD BE FALLING CRUMBLING TO THE SEA CAUSE MAYBE MAYBE THERE IS A FORCE ON THE EARTH THAT IF YOU WERE TO KNOCK THE RIGHT KNOCK AND TALK THE RIGHT TALK YOU WOULD THEN BE STALKED BUT IF YOU STEP IN AND YOU RECKONIZE THAT RIGHT BEFORE OUR EYES WILL MATERIALIZE YOUR FUTURE AND

> DEMISE WAS ONLY IN DISGUISE AND AS IT DECOMPOSE INTO SOMETHING NO ONE KNOWS YOU GIMMIE A BREAK WHILE I MANIPULATE YOUR MIND, YOU'RE MINE. (Harsh Reality, 2008, p.227)

Individually, none of the words used in the stanza are particularly hard to understand, yet the meaning of the text is difficult to grasp. Or is there a meaning? Perhaps the text does not seek to provide a deep meaning but is what it appears: a window into the thoughts and feelings of someone who is under the influence of crystal meth. Similar to the marvels described in "Kubla Khan", despite my best efforts and my competent reading ability, the capacity to fully comprehend texts like "Comastate subconscious" may be outside of my reach.

6.3 Suggestions for Future Editions of Harsh Reality

While this theme did not emerge in any of the focus groups or individual interviews, existing research would suggest that including specific information about sexuality, and particularly gay, lesbian, bi-sexual, lesbian, transgender and questioning (GLBTQ) sexuality would be a valuable inclusion in future editions. As outlined in Chapter 2, the street-involved GLBTQ population is often at heightened vulnerability for a variety of risks, from increased prevalence of suicidal ideation (Haldenby et al., 2007, p. 1233), to increased likelihood of engaging in survival sex and sexually risky behaviours such as early sexual debut and multiple partners (Zerger et al., 2008, p.832). A consideration for future editions may be to include some local resources which offer specific GLBTQ programming and support, such as Rainbow Resource Centre and the Sexuality Education Resource Centre, where GLBTQ street-involved youth might

access support and resources. In addition to a list of resources, the data suggests that personal narratives (such as poems and stories) resonate strongly with street-involved youth. In light of this finding, the inclusion of personal experiences of GLBTQ youth in future editions could be an effective way to connect with this segment of the street-involved population.

Based on the literature, another consideration for future editions would be to be aware of the font sizes used throughout the document. While concern about the size of font was raised by 1 male focus group participant in passing, studies suggest that due to the prohibitive cost of eye exams and contact lenses or glasses, street-involved youth who have vision problems may not have access to resources to improve their vision (Haldenby et al., 2007). This may result in problems being able to read small text, or text that is printed over a busy background.

Much of the existing literature about street-involved youth acknowledges that there are multiple subgroups beneath the umbrella of "street-involved youth" (Ensign & Santelli, 2007; Haldenby et al., 2007; Zerger et al., 2008). This lack of homogeneity should be reflected in resources for the street-involved population. Clearly, it is not pragmatic to try and address all subgroups in one resource. However, being cognizant of the different approaches that may be appropriate for different subgroups may assist in creating a positive impact from the resource. For example, Rotheram-Borus and colleagues suggest that, while promotion of condom use is important for all people who are sexually active, differentiated approaches can prove more successful with different genders (Rotheram-Borus et al, 2000, p.20). They continue to describe that for a female, often condom use requires the ability to effectively negotiate with her partner. As a

result, for females, information pertaining to how to initiate a discussion about condoms, and various negotiation strategies/assertiveness techniques may be beneficial. Contrarily, they describe that males tend to be more receptive to condom use if the approach appeals to sense of being a "protector". For this reason, an approach encouraging males to "protect" their partner may be beneficial (as opposed to information about negotiation skills). Future editions of *Harsh Reality* may want to include various strategies that may appeal to different subgroups when sharing information about a single topic.

Finally, in light of the strong positive response from focus group and individual interview participants to the narrative stories included in *Harsh Reality*, it is recommended that this continue to be a means to share information both about individuals' experiences, and health-related information. Further, a potential area to explore in future editions may be how narratives from differing perspectives about the same issue may present a fuller picture of the issue. For example, one of the male focus group participants suggested including more "positive" stories of people who had overcome challenges. Using the example of the topic of mental health, it may be beneficial to include narratives from people who are affected by the topic in different ways: one person who is affected by a family member who has mental health challenges, one person who is affected with mental health challenges himself, and perhaps a "success story" of someone who is able to effectively manage his mental health disorder. Due to pragmatic constraints about the size of the resource, while this would not be a feasible approach for all of the topics, it could be beneficial strategy to draw attention to some of the key messages or topics in the resource.

6.4 Findings Regarding Guiding Research Questions

As outlined in Chapter 1, several guiding research questions directed this evaluation. Pertaining to the process distribution, these questions were:

- Did the target audience of street-involved youth between the ages of 14-24 receive the *Harsh Reality?*
- If *Harsh Reality* was received by the target audience, which methods of resource distribution were most effective at reaching this population?

Based on the evaluation data, I would propose that approximately 1/3 of Winnipeg's street-involved youth between the ages of 15-24 received the resource. This approximation is based on the data that approximately half of the 100 individual interview participants had seen *Harsh Reality* prior to the evaluation (45), in addition to the consideration that of the 375 people contacted during individual interview data collection, 98 (26%) described having previously seen *Harsh Reality*. Beween ½ and ¾ of the focus group participants had seen *Harsh Reality*. However, this must be considered with the knowledge that, since these participants were recruited from community resource centres where the resource was distributed, it is more-likely that these participants would have been exposed to the resource.

Of the 45 individual interview participants who were already familiar with the resource, 27% (12 participants) received *Harsh Reality* directly from a distributor. Of the 98 contacts who reported having seen *Harsh Reality*, 14 described receiving a resource from a distributor in the community. Eleven of the 98 contacts received a copy of *Harsh Reality* from Margaret or me during the Metis and Manitoba First Nations Aids Working Group AIDS Conference at the Victoria Inn. While these 11 did not necessarily

receive the resource "out in the community", if this method of distribution is included as "receiving the resource from a distributor", then that increases the number of contacts who received a copy from a distributor to 25%. Based on this information, it would be recommended to continue to employ this method of distributing the resource to the target audience. Particularly in light of the challenges other studies have described in accessing street-involved youth (Haldenby et al., 2007; Zerger et al., 2008), using a method that accesses youth who are outside of the scope of those currently using services can increase the types of subgroups receiving the information.

Of those participants and contacts who received *Harsh Reality* via a community resource centre, RaY was specified as the site where individuals saw the resource more frequently than any other organization (including Siloam Mission, B&L Resources and Ndinawe). This data would suggest that the staff at RaY are doing an effective job of making the resource available to youth, and that RaY should continue to be used as a site of resource distribution in the future.

The impact outcome assessment aimed to gain information about the following areas:

- Youth knowledge of HIV testing facilities in Winnipeg
- Youth knowledge of the different types of HIV tests available
- Youth knowledge of Research Round-Up articles

The data would suggest that the majority of the individual interview and focus group participants were able to suggest possible sites of HIV testing in Winnipeg. However, the majority of the responses were suggested based on the fact that they were locations where one could seek medical attention for a variety of issues, and not because

youth knew that the location offered HIV testing (for example: hospital, walk-in clinic, Klinic). While there is a list of "Health" resources listed on the map in the back cover of *Harsh Reality*, the only article where testing sites are specifically referenced is in "HIV testing: Old stuff/new stuff". In this article, the only testing site in Winnipeg specifically identified is Nine Circles Community Health Centre. Twenty-five percent of individual interview participants named this as an HIV testing location.

It is unknown if the youth working group was aware that youth knowledge of HIV testing facilities in Winnipeg was one of the primary outcomes that *Harsh Reality* hoped to achieve, or if this outcome was selected after the resource had been completed. Ideally, if the youth working group was aware of the educational priorities during the creation of the resource, strategies such as repetition of the key information, the inclusion of colourful, engaging and relevant images, and a reduction in the amount of text could be applied. Perhaps in future editions, a specific list of HIV testing facilities in Winnipeg (and their addresses) could be included, in addition to a text-based article (such as "HIV testing: Old stuff/new stuff") and the health sites listed in the back cover with the map. By providing the information in multiple formats and in multiple locations, and increasing the visual appeal of the information (such as images and colour), the likelihood that a youth would see the information when "flipping through" the resource would be amplified.

Similar suggestions might be useful to increase knowledge of the different types of HIV testing available. The text-heavy nature of "HIV testing: Old stuff/new stuff", the lack of colour and humor, and the inclusion of few graphics may have failed to sufficiently engage youth to read the article. Reading about the different types of HIV

tests might seem rather dry compared to other articles focused on sex and drugs. By reducing the amount of text and trying to infuse some humor into the content, or perhaps presenting the information in and around really appealing art (such as graffiti), youth may be more apt to read the article. As another suggestion, perhaps a narrative story of someone who had gone to have one of the types of HIV tests would be an alternative method to present the information in a format that was found to be popular with the participants. Also, in future editions, it would be valuable to explicitly state that urine tests and pap tests (two common "other types of testing" suggested) do not test for HIV.

While initially only 14 of the 100 individual interview participants cited remembering a Research Round-Up article, after seeing the corresponding pictures, this number had increased to 70. It was clearly an effective strategy to include interesting graphics with these articles in order to draw youth's attention to the page. The article "Female Caucasian meth users most likely to share needles" was consistently referenced as one of the most frequently remembered Research Round-Up articles. This may have been influenced by the use of humor in the graphic, the shortest word count compared to the other Research Round-Up articles (247 words), and the fact that this article was at the most accessible reading level (approximately grade 6).

It is noteworthy that multiple participants in the focus groups stated that they looked at the RRU pictures but did not read the articles because they appeared "too long" or that the words were too difficult. While the male and female focus group expressed that providing information about research in Manitoba is a valuable component of *Harsh Reality*, the articles must be written at a lower readability if they are to be accessible to the street-involved population. Further, it seems that the shorter

an article is, and the more engaging the picture (particularly if there is colour), the more likely the article will be read.

6.5 Limitations and Challenges

One of the most important elements in undertaking a project such as this, is the ability to identify and learn from the limitations and challenges presented throughout the evaluation. In terms of both the distribution and evaluation of *Harsh Reality,* one potential issue is that some of the youth involved in explicitly high risk activities may not be as likely to be approached by either a distributor or myself as an evaluator. For example, if I encounter youth who appear to be heavily under the influence of drugs or alcohol, or youth who are actively engaged in illegal activity (such as selling drugs) – I would be less likely to approach those youth in light of safety precautions. This may constitute an ethical issue because youth who are at heightened risk and who might benefit most from the information in *Harsh Reality* may not receive the resource due to safety concerns on the part of the distributor or evaluator.

While I am reluctant to use the word "challenge", a "consideration" of this evaluation is the use of honoraria. Monetary compensation, particularly when working with the demographic of street-involved youth, carries with it a number of implications that may affect the evaluation.

The safety of the evaluator, in this case Margaret or myself, must be considered as part of the evaluation. Street-involved youth often frequent areas of Winnipeg in which crime rates are elevated (such as the Point Douglas area, or the North End). Often areas with elevated crime rates tend to be the same areas with a low socio-economic

status. While common sense would dictate that it would not be recommended to go out and do data collection while carrying vast amounts of money, it was not uncommon to carry at least $100 (enough funds to complete 10 individual interviews). In some cases, news of someone walking around a community and "handing out money" quickly spread (I remember a participant on Portage shouting to his buddies that the "blonde lady is handing out money!"). This can raise issues both in terms of evaluator safety and validity of evaluation findings. When dealing with individuals of a low socio-economic demographic, it is possible that youth might be dishonest about being familiar with the resource, or about being in the target age range (14-24) in order to participate in the evaluation and receive the $10 honoraria. As a result, I tried to mitigate this by not doing too many evaluations in one location at one time. By continually moving to new locations, this reduced the likelihood of news of "handing out money" circulating in the neighbourhood, and reduced the likelihood that someone might have heard about the honoraria and "fudge" personal details in order to participate.

Of course, the safety of the researchers is not the only safety that must be considered during the evaluation. Factors such as low-literacy, low socio-economic status, and possible mental health and/or addiction issues contribute to the vulnerable nature of the participant population. It was important to recognize the power imbalance that existed between myself as a researcher and the participant, particularly if the youth has been made aware that there is an honorarium involved for participation. There may be some youth who would be willing to put themselves at great risk in order to earn $10. Therefore, even if a youth was very eager to participate in the evaluation, it was necessary exhibit diligence in explaining the purpose and nature of the evaluation to

participants, going through the informed consent process, and following necessary ethical protocols.

Another factor which may affect the validity of the findings is the sobriety of the participants. Some circumstances lent themselves to being able to identify if a youth was under the influence of drugs or alcohol more than others. For example, substances such as marijuana, mouthwash, or inhalants often present with a strong odour. However, even these substances that present a strong odor might only be detectable at close range. With many substances that do not present with a strong odour, short of observing unusual behaviour (such as stumbling or slurred words), it can be difficult to determine if a youth is under the influence. Use of substances such as pills, injection drugs, or odourless liquids such as vodka can be difficult to identify. While I am not aware of any youth who were under the influence while participating in the evaluation, short of performing blood tests, it would be impossible to know for sure. This could constitute an ethical challenge if a participant who participated in an interview was actually under the influence and therefore ethically unable to grant informed consent.

As described in Chapter 2, transience is one of the hallmarks of street-involved youth. The transient lifestyle of street-involved youth may have posed a challenge in finding youth who had previously seen *Harsh Reality*. In addition to general mobility, the months of data collection, October through March, included the coldest months of the year. This may have affected the number of street-involved youth who traveled elsewhere in search of a less extreme climate. This transience and reduced visibility of youth can make finding participants to complete the evaluation challenging, but not insurmountable. It was important to try and observe how popular hang-outs changed

with climate, and other extenuating circumstances. As an example of an extenuating circumstance, Portage Place mall appears to employ more security guards during the weekends. Therefore, if I wanted to do data collection near Portage Place mall, there would likely be more street-involved youth hanging out in that location (as opposed to just walking through that location) during the week when there is less security present.

In their article "Ethical dilemmas in evaluations using indigenous research workers*"* (2008), Alexander and Richman highlight multiple considerations associated with using indigenous and non-indigenous individuals to conduct research. When conducting an evaluation such as this, "the target research populations are often hard to reach and are understudied, which makes them highly relevant to health disparities" (Alexander & Richman, 2008, p.73). As one way of trying to address this inaccessibility, Alexander and Richman suggest that the use of "indigenous" researchers, researchers who have shared experiences with the target population. Alexander and Richman describe that these shared experiences can include "living in the same neighbourhood, having similar cultural understandings about life, being of the same social class and educational background…and/or having personal experience with the focal problem addressed by an evaluation project" (2008, p. 74). An indigenous researcher may be more aware of the best locations and methods to interact with the target population. I am not "indigenous" to the street-involved population in Winnipeg. However, this limitation was mitigated in-part by doing data collection with Margaret who, while not street-involved, has gained so much experience working with this population that she was able to share a wealth of information with me.

Another potential strategy to explore in order to gain access to less visible street-involved subgroups would be to use a different sampling method. Methods such as snowball sampling in which several initial participants "nominate or recommend others who are known to have the profile, attributes, or characteristics desired" in participants (McMillan, 2008, p.121) could be beneficial in accessing street-involved youth who were not visible on the street or in the community.

The issue of accessibility proved to be a limitation in recruitment of focus group participants. The attempt at executing a focus group comprised of individuals not affiliated with an organization was not able to materialize owing to the fact that none of the participants showed up. Perhaps a way to mitigate this in the future would be to do recruitment of participants right before the focus group was planned to begin (for example, if the focus group is planned to begin at 3:00, walk around the surrounding neighbourhood at 2:00 to recruit youth to participate). By using this approach, participants can decide if they are interested in participating and, if so, can immediately go to the nearby focus group location. This negates the challenge of participants having to remember a pre-arranged date and time. However, the drawback of this approach is that if there are not many youth in the surrounding area during recruitment, the focus group might end up with very few participants (or none at all).

Finally, a further limitation to the data is that approximately half of the individual interview participants (55) had not seen *Harsh Reality* prior to the evaluation. These individuals were given as much time as they wanted to read through the resource before the interview (generally they took between 10-15 minutes). Similarly, in the case of the female focus group, the majority of the participants had not seen the resource until

earlier that day (4 of the 6). These participants were also given 15 minutes to look through the resource. However, it is unlikely that an individual could really familiarize himself with a 240 page resource in such a short period of time – particularly if he has a low literacy level. While the feedback from these 55 participants was very valuable, if all of the participants had more time to go through *Harsh Reality*, they may have had additional comments or insights to share.

6.6 Implications of the Harsh Reality Evaluation

Currently, a Latin American Caribbean Research Exchange Grant has been obtained to support a growing partnership between the University of Manitoba (UM) and the University of Antioquia (UDEA) in Medellín, Colombia. The faculty of Medical Microbiology (UM) and the Faculty of Public Health (UDEA) have previously collaborated on a number of projects in recent years, including providing rapid HIV testing in a Colombian indigenous community, and providing HIV testing to sex trade workers within the city of Medellín.

Borrowing elements from the creation and evaluation of *Harsh Reality*, a pilot project has been undertaken in Medellín to determine if a similar method of resource creation and dissemination can also be applied in Colombia. In June, 2010, the project team completed five focus groups with street-involved youth (both affiliated with, and not affiliated with institutions) in order to obtain contextual information about their lived experiences, and the issues and themes that they describe as important and valuable. From this information, a 2 page print resource, *Abre los Ojos* (Open Your Eyes) was

created and distributed in February, 2011. The style of *Abre los Ojos* is very similar to *Harsh Reality* in that it is edgy, art-oriented, and contains direct and candid information.

Figure 6.2 Abre los Ojos pamphlet

(Abre los Ojos, 2011)

Again, borrowing from the types of outcome and dissemination questions posed in the *Harsh Reality* evaluation, in February, 2011 one-hundred quantitative interviews and four focus groups were conducted to obtain feedback about the resource from street-involved youth in Colombia. This data is currently being analyzed, and will be used to inform future educational resource development for this population in Medellín.

6.7 Potential Areas for Further Investigation

The results from the *Harsh Reality* evaluation support the conclusion that the language used throughout the resource was well-received by the target audience. The language was referred to by participants as “funny”, “direct” and “straight-up”.

However, while the language may have made the resource more enjoyable to read – did it encourage learning?

The appeal of "shock value" is by no means limited to the target population of street-involved youth alone. The book *Skinny bitch*, a sassy diet and nutrition guide, made it onto the New York Times bestseller list shortly after its publication in 2005. The appeal of *Skinny bitch* is that the authors, Rory Freedman and Kim Barnouin, present nutritional information in a different and more shocking and blunt manner than most nutrition guides. Take, for example, this passage describing why one should abstain from alcohol:

> Of course it's easier to socialize after you've had a few drinks. But being a fat pig will hinder you, sober or drunk. And habitual drinking equals fat-pig syndrome. Beer is for frat boys, not skinny bitches. It makes you fat, bloated and farty…And don't kid yourself: When you have a hangover, you're bound to eat shit all day long. (Freddman & Barnouin, 2005, p.12)

I can remember reading part of *Skinny bitch.* I remember that the section I read was quite funny. I remember it kept hammering home the idea of not drinking milk, but I don't remember why (and subsequently, I still drink milk). So, *Skinny bitch* begs the question: is the goal of merely getting someone to *want* to read a resource enough? Is the target audience having the desire to read and/or actually reading a resource sufficient – or is the goal to have the target audience *learn* information which could hopefully inform and influence behavioural change?

Clearly, in order to learn the information, one needs to first read the resource. However, I am curious if the key message is detracted from, or enhanced, through the

use of humor, specifically "shock value" humor and language. That being said, if one's normative language uses "shocking" and explicit terms – perhaps the shock value factor is not as noticeable. However, even in the male focus group where participants were quite liberal with their language during conversations before and even during the formal conversation, several participants made the comment that they were "surprised" by the language used in *Harsh Reality*. I would be very interested to explore different methods of sharing information about a single topic; one method could involve sharing information in a "shock value" way, the other method could involve sharing information in a way that does not employ shock value, then gaining participant feedback on both the enjoyment of reading the resource, and measuring the uptake of specific educational outcomes.

6.8 Personal Response to Data and Conclusion

In February, 2011, I had the opportunity to spend a few weeks working on the *Abre los Ojos* project in Medellín. I was staying in a hotel in a different neighbourhood than usual, and I enjoyed exploring the surrounding community each evening when I would wander around looking for a restaurant to eat dinner. One day, I stumbled across a tiny café a few blocks from the hotel. The only customer inside amidst the eight tiny tables, I was able to meet the owner of the restaurant (who was also the server and the cook). Without exaggeration, the dishes that Fernando prepared were some of the best food I have ever had. The presentation, the flavors, the time he took to prepare, and the pride with which he served his dishes made dining at El Cactus a very memorable experience. For Fernando, his food was his art, his heart, his passion – on a plate. Not

wanting to appear like I was stalking Fernando, I tried to space out the frequency with which I visited his restaurant. But particularly when I ate lunch at his restaurant, dinner somewhere else always seemed like a disappointment. After lunch at El Cactus, while dinner was consistently fine, the food just seemed flat and lifeless on the plate. There was no spark. How could I have known that these dining experiences at Fernando's restaurant would trigger my own epiphany regarding the data from this evaluation?

As previously described, in order to organize the data collected from both the focus groups and the individual interviews, I created an Excel spreadsheet to organize the participants' responses. Each question had a separate sheet in the Excel workbook, each row and column neatly labeled. It was, I think, a tidy and organized (albeit very time consuming) strategy for organizing the data. But as I looked over my pages of spreadsheets to do the analysis, I couldn't help but feel like they were…flat. Just like the food at the other restaurants, I could just tell there was something missing. Of course, the squares were neatly filled up with data; but I felt as if the data was talking around the subject instead of engaging in it. In looking at the spreadsheets, I did not feel like the consecutive tidy rows of cells and compartmentalized topics reflected the kids I had talked to. Their lives weren't neat or orderly. Their lives were messy and chaotic and no one variable could be isolated from anything else. As "artsy" as it may sound, I felt like the data had no spark; it had no heart.

I began to think about how I could make the data capture the vibrancy of the participants, and how I had been changed by the experience of spending time with them. I did not feel moved by looking at the spreadsheet. I did, however, feel moved by listening to the kids' stories during the interviews and focus groups. As a result, I

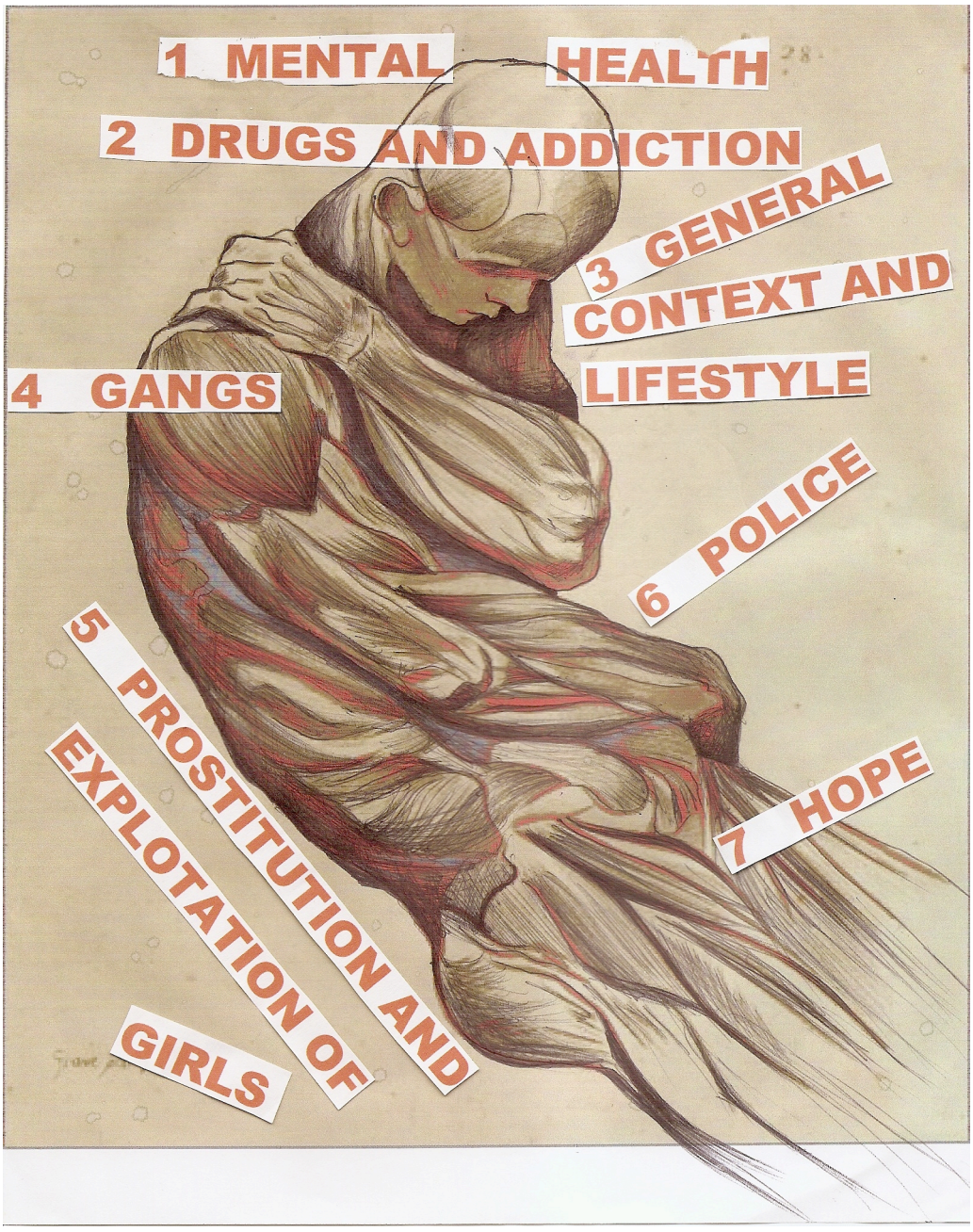
returned to the focus group transcripts and created a Word document summarizing all of the "filler" comments; comments that were not specifically answering an evaluation question, but that provided valuable contextual information about the lives of the participants (please see Appendix G).

To me, this document has become the heart of this evaluation. In preparing my presentation for the Graduate Student Symposium in March, 2011, I wanted to incorporate my discovery of this crucial element of the *Harsh Reality* evaluation. I contacted an artist I met in Medellín, Oliver Zamora Suaza, and asked if he might be able to create a piece of art that embodied these comments. The following are the images Oliver created based on the participants' words:

Figure 6.3 Image 1 based on participants' life experiences

(by Sir Oliver Zamora Suaza, 2011)

Figure 6.4 Image 2 based on participants' life experiences



(by Sir Oliver Zamora Suaza, 2011)

In order to help the audience at the Graduate Student Symposium understand the words that the images were representing, I chose some of the comments I thought were most powerful to display surrounding one of the images.

Figure 6.5 PowerPoint slide used at graduate student symposium

To me, the document summarizing the participants' experiences is the most valuable thing I have learned from participating in this evaluation. While, of course, I have learned tremendous amounts about program evaluation, and data collection and analysis – learning more about the population of street-involved youth in Winnipeg has been the experience that has changed me. If data analysis had consisted of spreadsheets and tally charts alone, I think I would have missed the most important component of the evaluation. Certainly, I can recite statistics and facts about target reading levels and the

benefits and challenges of a harm reduction approach, but I will never be able to design a resource *for* street-involved youth if I don't engage meaningfully *with* street-involved youth. Margaret once told me that she thought it was unethical for researchers to work with vulnerable populations and not be, at least somewhat, emotionally invested in them. I would have to agree, but I can also see how it happens. That is not to imply that all data "has no heart". But data divorced from the context of the participants can limit one's ability to connect, on more than a purely cerebral level, with one's research topic.

This idea of interconnectivity is central to HIV/AIDS education. We can't go and teach kids AIDS related facts without considering the context of the learners. We can't slap a "wear a condom" message on a billboard and expect transformative behavioural change without talking to people to understand why they aren't using condoms. Life is messy. Nothing is neat and linear, and rarely does one aspect of life exist in isolation. Clearly, it is not pragmatic to suggest that an HIV/AIDS education program could aspire to address *all* aspects in the context of its target audience. But certainly, designing programs and interventions blind to the context and influences and interconnectivity of people's situations will only achieve fractions of the success that could be possible if these factors were acknowledged.

In learning about people's lived experiences, there is not only value for the person learning but also the person sharing. During individual interview data collection, at the conclusion of the interview, I would explain that, after receiving the honorarium, the participant had to write only her initials on the Honorarium Form. I was surprised at how many participants asked me if they could sign their full name instead of putting their initials. Their desire to sign their name, to be recognized as individuals, and to be

counted as people who had shared their opinions, was something that moved me deeply. It made me wonder about how many times these youth had ever been asked what they thought about something; or how many times they had been told that their perspective mattered.

In my very first class in the graduate program, I was assigned to read *Pedagogy of the oppressed* by Paolo Freire (2007). I found the book transformational, and have quoted it in almost every paper I've written during my time in the program. Freire does not gently encourage, but rather implores educators to engage in partnership with oppressed populations in order to facilitate their education, and through education, their liberation. Winnipeg's street-involved youth are the type of oppressed population that Freire is referring to. Marginalized and vulnerable, they are at heightened risk for violence, exploitation, mental health disorders, health concerns such as sexually transmitted infections, and even death. Initiatives such as *Harsh Reality* offer an opportunity to partner with this population, to create meaningful opportunities for education, and an opportunity to create space for this population's unique voice. Freire describes that "no pedagogy which is truly liberating can remain distant from the oppressed by treating them as unfortunates" (Freire, 2007, p.54). Rather, it is only by reducing that distance through collaboration, by learning about a population's lives and experiences, and through the sharing of ideas and "opening of the question box" to see what the population knows and wants to know that truly effective and liberating education can take place.

The formal evaluation of *Harsh Reality* has come to an end. The audio tapes are transcribed. The spreadsheets are filled. The data has been analyzed and the findings

discussed. Yet, as Freire describes, “dialogue is never an end in itself but a means to develop a better comprehension about the object of knowledge” (Freire, 2007, p.18). The conclusion of this evaluation is now a beginning; an opportunity to share information with others, and an opportunity to challenge myself to apply what I have learned to future education initiatives for vulnerable populations regarding HIV and AIDS prevention.

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Appendix A – Letter from Health Research Ethics Board

UNIVERSITY OF MANITOBA

BANNATYNE CAMPUS
Research Ethics Boards

P126-770 Bannatyne Avenue
Winnipeg, Manitoba
Canada R3E 0W3
Tel: (204) 789-[redacted]
Fax: (204) 789-[redacted]

APPROVAL FORM

Principal Investigator: Dr. J. Wylie

Ethics Reference Number: H2009:124
Date of REB Meeting: April 27, 2009
Date of Approval: May 22, 2009
Date of Expiry: April 27, 2010

Protocol Title: "Harsh Reality": Evaluation of Educational Material Targeted Towards Street-Involved Youth

The following is/are approved for use:

- **Research Proposal, Version submitted April 14, 2009**
- **Questionnaires & Interview Questions (Appendices C-F), Versions dated 2009/04/14**
- **"Harsh Reality" (Appendix G), Submitted April 14, 2009**
- **Information and Consent Form for Youth Interviews, Version dated 2009_04_14**
- **Information and Consent Form for Focus Groups, Version dated 2009_04_14**
- **Information and Consent Form for Community Health Staff, Version dated 2009_04_14**
- **Information and Consent Form for Distributors, Version dated 2009_04_14**

The above was approved by Dr. John Arnett, Ph.D., C. Psych., Chair, Health Research Ethics Board, Bannatyne Campus, University of Manitoba on behalf of the committee per your letter dated May 9, 2009. The Research Ethics Board is organized and operates according to Health Canada/ICH Good Clinical Practices, Tri-Council Policy Statement, and the applicable laws and regulations of Manitoba. The membership of this Research Ethics Board complies with the membership requirements for Research Ethics Boards defined in Division 5 of the *Food and Drug Regulations of Canada.*

This approval is valid for one year from the date of the REB meeting at which the study was reviewed. A study status report must be submitted annually and must accompany your request for re-approval. Any significant changes of the protocol and informed consent form should be reported to the Chair for consideration in advance of implementation of such changes. The REB must be notified regarding discontinuation or study closure.

This approval is for the ethics of human use only. For the logistics of performing the study, approval must be sought from the relevant institution, if required.

Sincerely yours,

[redacted]

John Arnett, Ph.D., C. Psych.
Chair, Health Research Ethics Board
Bannatyne Campus

Please quote the above Ethics Reference Number on all correspondence.
Inquiries should be directed to the REB Secretary **Telephone:** (204) 789-[redacted] / Fax: (204) 789-[redacted]

Appendix B – Questions for Individual Interview

Location: _____Time:_____

1. Gender **Female** **Male** **Transgender**

2. How old are you? _____

3. Are you in school? **Yes** (grade___) **No** (graduated/last grade __)

4. What is your ethnic background? **Aboriginal/Metís/Inuit** **European/Caucasian**

African/Middle Eastern **Asian/Indian**

*** Show "Harsh Reality" ***

5. Have you seen or heard about this copy of Harsh Reality? **Yes** **No** **Unsure**

If no, show the cover of Harsh Reality from last year. Ask if they have seen or heard of the previous copy of Harsh Reality. **Yes** **No** **Unsure**

If no, explain what Harsh Reality is. Ask if they want a copy. Skip to # 11.

If Yes:

5.1 What is it? _____

5.2 Where did you see it? **Distributor** **Health Centre**

Friend **Drop-in Centre**

Other: _____

5.3a Do you/did you have a copy? **Yes** **No**

5.3b If yes, what did you do with it? **Kept it** **Gave it away**

Don't know

6.a Did you read any of HR? **Yes** **No**

6.b If yes, how much? **Whole thing** **About half**

About ¼ **Flipped through**

7. What do you remember about HR?

_____

_____

8. Was there anything you learned from HR? (if they learned multiple things, ask which was the most important)

_____

_____

9. What do you like the most about HR?

_____

_____

10. What do you dislike the most about HR?

_____

---

11. What do you think of the look of Harsh Reality? (pictures, graphics, etc). Why?

Strongly Like **Like** **Neutral** **Dislike** **Strongly Dislike**

_____

_____

12. Do you think that Harsh Reality contains information that is interesting or valuable?

Yes (specifics)_____

No (what would you want information about?) _____

If they haven't read HR, skip to question #14.

13. Do you remember seeing/reading any articles called "Research Round-Up"?

Yes **No**

13.1 If yes, do you remember what they were called or what they were about?

Yes Bac on the Rise Bac protects your bits

STDs in Mb youth Meth users

No

13.2 (If no, show titles of the four articles on the next page) These were the titles, do you remember reading any of these or what they were about?

Yes Bac on the Rise Bac protects your bits

	STDs in Mb youth	Meth users

No

13.3 (If no, show pictures from the four articles) These were some pictures with the articles, do you remember seeing any of these or what they were about?

Yes	Bac on the Rise	Bac protects your bits
	STDs in Mb youth	Meth users

No

14. Do you know anywhere you could go for an HIV test?

Yes (go to a)	9 Circles	Family Dr	Other

No

14.1 How did you learn about that?	Harsh Reality	School	Friends
	Com. Health	Parents	Other

14.1b. If from HR: Do you remember what part of the book that was in?

15. Do you know the different kinds of HIV tests?

Yes	Name-based/nom.	Coded/non-nom.
	Anonymous	Rapid/POC

No

15.1 How did you learn about that?	Harsh Reality	School	Friends
	Comm. Health	Parents	Other

15.1b If from HR: Do you remember what part of the book that was in?

Appendix C – Individual Interview Consent Form

UNIVERSITY OF MANITOBA | Department of Medical Microbiology

Title of study: HARSH REALITY: EVALUATION OF EDUCATIONAL MATERIAL TARGETED TOWARDS STREET-INVOLVED YOUTH

Principal Investigator: Dr. John Wylie, Cadham Provincial Laboratory, Phone: 945-[redacted]

Graduate Student Supervisor Contact Information: Dr. Barbara McMillan, Faculty of Education, University of Manitoba, Phone: 474-[redacted]
Graduate Student Researcher: Chelsea Snarr, Faculty of Education, University of Manitoba, Phone: 226-[redacted]

Purpose: This study aims to get feedback from youth about the content of *Harsh Reality* as an educational resource for youth. Please review this consent form and ask any questions that you may have.

Procedure: You will be asked to take part in a 10- 15 minute interview about *Harsh Reality*. Your name will not be recorded. Following this study, all of the questionnaires will be destroyed.

Benefits of participation: The information from the interviews will help us improve future editions of *Harsh Reality*.

Payment: We will provide you with a $10 honorarium for participating.

Confidentiality: Information gathered in this research study may be published or presented in public forums. However, we will not use your name when we analyze the data.

Voluntary participation: Your decision to take part in this study is voluntary. You may stop participating at any time.

Questions: You are free to ask any questions that you may have about the study. If you have any questions after the interview is completed you may contact study staff using the phone numbers above.

Statement of consent:
I have read this consent form and have had the opportunity to discuss this study with Chelsea Snarr or the study personnel. I have had my questions answered and I understand that I will be given a copy of this consent form. I understand that my participation is voluntary and that I can stop participating at any time. I also understand that my name will not be identified.

> **Your oral consent to Chelsea Snarr or one of the investigators indicates that you understand this information about participating in the Harsh Reality Interview and that you agree to participate.**

Participant's name _____ Date _____

Oral consent obtained □ (check box)

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent.

Researcher's signature _____ Date _____

Appendix D – Focus Group Participant Consent Form

UNIVERSITY OF MANITOBA | Department of Medical Microbiology

Title of study: HARSH REALITY: EVALUATION OF EDUCATIONAL MATERIAL TARGETED TOWARDS STREET-INVOLVED YOUTH

Principal Investigator: Dr. John Wylie, Cadham Provincial Laboratory, Phone: 945-[redacted]

Graduate Student Supervisor Contact Information: Dr. Barbara McMillan, Faculty of Education, University of Manitoba, Phone: 474-[redacted]
Graduate student researcher: Chelsea Snarr, Faculty of Education, University of Manitoba, Phone: 226-[redacted]

Purpose: This research study is being conducted to evaluate the effectiveness of *Harsh Reality* as an education resource for youth. Please review this consent form and ask any questions that you may have.

Procedure: In this study you will be asked to take part in a focus group discussion about *Harsh Reality*. This discussion will be audio-taped but your name will be deleted when the tape is transcribed. Following transcription the tape will be destroyed. To take part you will be asked to review Harsh Reality and then take part in a 60-90 minute discussion.

Benefits of participation: We expect the results of the evaluation will help us improve future editions of *Harsh Reality*.

Payment: We will provide you with a $20 honorarium for participating.

Confidentiality: Information gathered in this research study may be published or presented in public forums. However, as mentioned above, we will not use your name when we analyze the data. Please note that the group format of a focus group discussion means that absolute confidentiality can not be guaranteed. However, measures will be taken to protect your confidentiality as much as possible (for example: at the beginning of the discussion, the facilitator will outline that participants should not repeat individual's comments outside of the focus group).

Voluntary participation: Your decision to take part in this study is voluntary. You may withdraw at any time.

Questions: You are free to ask any questions that you may have about the study. If you have any questions after the focus group is completed you may contact study staff using the phone numbers above.

Statement of consent:
I have read this consent form and have had the opportunity to discuss this research with Chelsea Snarr or the investigators. I have had my questions answered and I understand that I will be given a copy of this consent form. I understand that my participation is voluntary and that I can withdraw at any time. I also understand that the interview will be audio-taped and that my name will not be identified.

> **Your oral consent to Chelsea Snarr or one of the investigators indicates that you understand this information about participating in the Harsh Reality Focus Group and that you agree to participate.**

Participant's name _____ Date_____

Oral consent obtained □ (check box)

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent.

Researcher's signature _____ Date_____

Appendix E – Distributor Consent Form

UNIVERSITY OF MANITOBA | Department of Medical Microbiology

Title of study: HARSH REALITY: EVALUATION OF EDUCATIONAL MATERIAL TARGETED TOWARDS STREET-INVOLVED YOUTH

Principal Investigator: Dr. John Wylie, Cadham Provincial Laboratory, Phone: 945-[redacted]

Graduate Student Supervisor Contact Information: Dr. Barbara McMillan, Faculty of Education, University of Manitoba, Phone: 474[redacted]

Graduate Student Researcher: Chelsea Snarr, Faculty of Education, University of Manitoba, Phone: 226[redacted]

Purpose: This research study is being conducted to evaluate the effectiveness of the content and distribution methods of *Harsh Reality*: an education resource for youth. Please review this consent form and ask any questions that you may have.

Procedure: In this study you will be asked to take part in an interview about *Harsh Reality*. This discussion will be audio-taped but your name will be deleted when the tape is transcribed. Following transcription the tape will be destroyed. To take part you will be asked to review Harsh Reality and then take part in a 45–60 minute interview.

Benefits of participation: We expect the results of the evaluation will help us improve future editions of *Harsh Reality*.

Payment: We will provide you with a $20 honorarium for participating.

Confidentiality: Information gathered in this research study may be published or presented in public forums. However, as mentioned above, we will not use your name when we analyze the data.

Voluntary participation: Your decision to take part in this study is voluntary. You may withdraw at any time.

Questions: You are free to ask any questions that you may have about the study. If you have any questions after the interview is completed you may contact study staff using the phone numbers above.

Statement of consent:
I have read this consent form and have had the opportunity to discuss this research with Chelsea Snarr or the investigators. I have had my questions answered and I understand that I will be given a copy of this consent form after signing it. I understand that my participation is voluntary and that I can withdraw at any time. I also understand that the interview will be audio-taped and that my name will not be identified.

> **Your signature on this form indicates that you understand this information about participating in the Harsh Reality Interview and that you agree to participate.**

Participant's signature _____ Date _____

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent.

Researcher's signature _____ Date _____

Appendix F – Distributor Interview Questions

Section 1: Involvement & Locations

1. Was this your first year distributing HR (2008)?
    - If not, when were you involved before?
2. How many times did you go out and distribute HR in 2008?
3. How did you get involved with distributing HR?

Section 2: Distribution on the Street

4. Which were the locations that you went to?
    - Which locations do you remember as the most successful? Why?
    - Least successful? Why?
5. Was there a particular time of day that you found most successful? Why?
    - Least successful? Why?
6. What were the youth's responses to you giving them HR?
7. What would be some important things for a "new distributor" to know before heading out to hand-out HR (safety precautions, do you approach all youth or only select youth, effective ways to approach someone, etc.)?
8. What do you think are the positives and the limitations of distributing HR in this way?

Section 3: Distribution at Community Centres

9. How many HR would you estimate that you gave out using this method?
    - Do you have an estimate of the total number of HR that were given out using this method?

- How did you drop HR off (gave it to staff, gave it to youth, left it on the counter, etc.)?
- If HR was given to a staff person, did you provide any explanation about what it is and how it could be used? If so, how did you explain it?
- If HR was given to youth, was the same dialogue used as when HR is delivered to youth on the street?

10. What are the community centres where you dropped off HR?
    - Which locations do you remember as the most successful? Why?
    - Least successful? Why?

11. What do you think are the positives and the limitations of distributing HR in this way?

Section 4: Personal Response and Future Planning

12. Do you think that HR is a valuable resource for youth? Why or why not?
    - What are your favourite components of HR? Why (because you contributed to them, interesting, most valuable information, etc.)?
    - Least favourite? Why (not valuable information, not interesting, etc.)?

13. Did you help with the creation of HR 2008?
    - If so, how did you contribute?

14. Are there any improvements you would suggest for HR 2009?

Appendix G – Focus Group Participants' "Filler Comments"

Mental Health

"Like the bi-polar part [was relevant], growing up with bi-polar disorder, anxiety, depression…and the oxycontin part. I live addicted to oxycontin everyday so I related to that a lot."

"I have been diagnosed with bi-polar disease. I'm doing pretty well with my bi-polar… I do have my ups and my downs."

"I suffer from severe depression too. I'm on medications."

Drugs & Addiction

"I go to Street Connections to pick up my supplies [needles] every couple of days or whatever."

"Opiates…that's like an epidemic in the city here now… It's so bad in the city that it's ridiculous."

"For me personally, I'm probably more addicted to the needle than I am the drug."

"I'm noticing crack is more social, it's more of a social drug. Everybody can sit down and smoke a piece at a party and nobody would say nothing."

"Pharmaparties. That's where you just put your hand in a bowl of pills and then take a shot of whiskey and yeah, make a cocktail."

"I'm an addict and I live a harsh reality myself."

"I have more than one addiction. I have like four or five. I drink, I smoke weed, I smoke some rock every now and then. I do morphine every now and then, or oxys."

"There's not that many meth users in the city anymore, though. There used to be a lot back when it was cheap…There's more people using oxycontin and stuff."

"I remember when there was lots of people using meth. Now there's more people using coke and pills… There's more people doing more coke and pills than alcoholics."

"You're not a terrible person because you use drugs, or are addicted to drugs. I don't know if I should dare to say you're a victim…'Cause like, being an addict is almost like being victimized."

"There's a person inside of every addict. Like me, I'm an addict but I'm a real person. I'm not just an addict."

"I suffer from addiction. And addiction I do believe is a disease. And it sucks. Hard."

"When she overdosed she just nodded out…and she kept falling forward and then all of a sudden she *smack* and hit the floor. And then her lips were purple, her eyes were purple around her eyes and her fingertips and she was white all over…she was just dead. And then, I didn't know what to do…I just called 911. But I saved her life, that's what they told me anyway."

"Within my first 8 hours of being in Winnipeg, I had someone offer me a sheet of acid for $20."

General Context & Lifestyle

"Diabetes. I just got diagnosed. Nobody in my family has it."

"My whole family has diabetes. I had a couple of family members who died of diabetes."

"I've only been back in Winnipeg for a month and, you know, I have legal problems, alcohol problems, women problems, hustler problems."

"I left Toronto for the same reasons: legal problems, women problems, drinking, drugs, and it made me scared. And I got bloodwork done as soon as I got back."

"There's a rumor going around and I don't know if it's true. I've got a girl who like won't leave me alone, and then there's another girl behind her doing the same thing, claiming she's pregnant."

"I grew up in a very abusive home and I got out, luckily, when I was young. But a kid that doesn't get out needs someone because they really…it really fucks 'em up."

"Growing up in an abusive home, my Dad was a cop. Who do I run to? Instead I just became really rebellious."

"I've been sexually active since I was like 14 and I had to learn from my mistakes."

"Growing up in Winnipeg you're gonna learn how to swear. You're gonna learn all about that type of stuff. You hear those words everywhere you go. You hear fuck, shit, bitch, all that stuff."

"There's not a lot of access to affordable fruits and vegetables in the inner city."

"People in the city should be more aware of what's going on in the street."

Gangs

"Thug life…I've got so much I could say about that because I grew up around that stuff."

"They think you'll get scared when they say their crew name. They expect you to run."

"The older guys try to push on you...like them pressuring you to get in or get down…and if you don't get down they'll kill you."

"And if you get beaten up lots they'll think you're a little bitch. You know, they'll beat you up when you walk past their shack or something."

"And when they're doing that to you and puttin' pressure on you, you don't want to, like some people will take it to the limit and be like 'fuck life, bye bye' and do it to themselves. Like they'll kill themselves. I've seen it happen."

"When there's no food in the cupboards at home and mom's out smoking crack or drinking, you know, gangs seem like the thing to do."

"I remember one time…I was watching people in the park eating a BBQ or something, playing a game…And I remember thinking 'how the hell can these guys survive without a gang?' I was wondering where does their money come from? And why are they not afraid that they're gonna get punched out or something? And when you're like that, when you're that vulnerable, it's like the only thing that come naturally is like signing up with a bunch of guys that have your back and will help you get money."

"But that's another thing with the gang life is that you can't always depend on homies to be there for you. Like what if you're at gunpoint and nobody's around?"

"There's chick crews that have just as much respect as the guys .They're just as violent as some of the guys so there's the respect."

"All these criminal people they put a veil in front of everybody's eyes. Like they try and get across that if you're a gangbanger, or if you're a prostitute you can get in all this money…it's a big lie, man."

Prostitution & Exploitation of Girls

"I know a few girls that just live with a guy…And these guys are like, they're dirty, they don't take care of themselves. They leave dirty needles around, crack pipes, and all that. And there'll be a young, smart, good looking girl that'll live with the guy just to get high all the time. And that's like, uh, that's like selling yourselves for sex…There's a lot more of that going on now."

"There's some guys out there that are putting girls out on the street to make their money, to hoot drugs up their [vagina]."

"Or the bosses out there that get their little girls and they let them smoke some crack and they get all fiended out and they say 'hey I've got some custies here that will pay for you to suck 'em off' or something. Shit like that happens all the time."

Police

"There are some cops out there that will take you, take you out to the perimeter highway, beat the shit out of you and make you walk home."

"They're supposed to be protecting their own people, basically. But there's cops out there that are racist. Yet we're not, like as a human race we're not supposed to be racist."

"I've seen a police officer beat up a native guy for no reason. He wasn't resisting, he wasn't nothing. Yeah, he was getting arrested but he wasn't resisting. They beat him with batons, they tazed him…It's like it's making me think what's this world coming to, man?"

"It's happened to me where they've actually shocked me in the back of the leg with a tazer and it hurts. I've never felt a pain like that in my life until then…It's intense. "

Hope

"[Some] people have waded through the shit and got out of it."