

What Goes Around: How Peers Use Their Social Networks
To Share Sexually Transmitted and Blood Borne Infections
Education and Information

by

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Abstract

Each year in Manitoba rates of many sexually transmitted and blood born infections (STBBI) are rising, including HIV and hepatitis C. Due to routes of transmission, safer sex and safer drug use information and resources are integral to prevention of new infections. Peer delivered information on STBBI within social networks is considered best practice for engaging, educating, and treating those most vulnerable to STBBI. Most research to date involves formal sources of information delivered by peers, which includes recruiting, training, and supporting peer leaders in delivering messages. This community based research project explored how the 595 Peer Working Group (595PWG) shares information on an informal basis within their social network. Seventeen qualitative interviews were conducted with participants and two quantitative surveys were administered to gather demographic information. The qualitative results indicated that 16 of the participants actively pass on safer drug use and safer sex information within their social networks. Safer drug use messages being passed on included: know how drugs will impact you and those you are using with; do not use drugs; do not share your drug use equipment; STBBI information; and how to acquire your drugs safely. Safer sex messages included: use a barrier; HIV, STIs and other infections; and know where to get safer sex supplies. Additionally, all 17 participants indicated that they distribute safer sex or safer drug use supplies among their social networks. Although this finding suggests that passing information is a natural and organic process among social networks, the data also highlights conditions under which information is shared as well as barriers to sharing information. Implications from this research highlight the need to increase peer-to-peer

knowledge sharing opportunities within organizations as well as increasing access to harm reduction supplies for peer-to-peer distribution.

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Dedication

All the work I put into this thesis is dedicated to two very special people:

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List of Acronyms

595PWG	The 595 Peer Working Group
AIDS	Acquired immune deficiency syndrome
BBP	Blood borne pathogens
CBR	Community based research
CIHR	Canadian Institute of Health Research
GLBTT*	Gay, lesbian, bisexual, transgender, Two-Spirit, and other people who are oppressed or marginalized in society because of any aspect of their gender or the ways that they express love and desire (www.getiton.ca)
Hep C	Hepatitis C
HIV	Human immunodeficiency virus
HR	Harm Reduction
IDU	Injection drug use
IV	Intravenous
MANDU	Manitoba Area Network of Drug Users
MFNAWG	Manitoba First Nations AIDS Working Group
PBO	Peer Based Organization
PSP	Peer Secretariat Project
STBBI	Sexually transmitted and blood borne infections
STI	Sexually transmitted infections
SWAT	Sex Workers Addressing Treatment
TERF	Transition, Education and Resources for Females
The 595	The 595 Prevention Team Inc.

UNAIDS Joint United Nations Program on HIV/AIDS

WRHA Winnipeg Regional Health Authority

Glossary of Terms¹

Bareback	To have unprotected penetrative sex (without a condom)
Clean	“Sober”, not using any drugs
Clean Supplies	1. Unopened, wrapped up in packaging , sterilized, new, unused 2. Used supplies that were cleaned with bleach
Chipping	1. Chipping off some crack/ coke and saving the rest 2. When dealing, chipping some off to sell extra 3.Using drugs every now and then 4. Chipping in, everyone chips in money to purchase drugs
Cooker	Equipment used for heating/ cooking injection drugs (e.g. spoon)
Dirty Supplies	1. Supplies that have been opened and touched by someone else2. Supplies that have been used, discarded, or expired; 3. “Dirty drugs,” drugs that have been cut with something else
Double up	1. Using two methods at the same time to use the same drug (i.e. inject it then smoke it) 2. To do two shots of IV drugs at once (one needle with two hits in it) 3. Double up on supplies
Fixing them	Injecting other people with drugs
Front	A drug dealer provides you with drugs “up front” and you pay for it at a later time
Hitting	Injecting other people with drugs
Hooked up	A dealer gives you free drugs
John	Sex work clients

¹ References for terms that are defined by an outside source will be cited in the body of the thesis.

Mental health	As defined/understood by the 595PWG members, this includes: addiction, depression, suicide, medication, stabilization with medication, co-occurring disorders, trauma, schizophrenia affected, post-partum, bi polar, post traumatic stress disorder
Mixing	Preparing drugs for injection
Pangender	“A person whose gender identity is comprised of all or many gender expressions”
Push	When you push the drug resin down the crack pipe and smoke it
Rigs	Needles
Sex Work	“Female, male and transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally, and who may or may not consciously define those activities as income-generating”
Social assistance	Employment and Income Assistance (also referred to as welfare)
Survival sex	The exchange of sex acts for money or in order to meet needs
Track	The streets where sex work is conducted
Transgender	“An umbrella term for people whose gender identity and/or gender expression differs from the sex they were assigned at birth. Transgender people may identify as female-to-male (FTM) or male-to-female (MTF)”

Chapter One - Introduction

1.1 Defining Moments

In the spring of 2012, I was sitting at my desk wrapping up my thoughts on a meeting I just had with the Peers² of the 595. As people were leaving I noticed Monica³, one of the Peers, hanging around and it was clear she wanted to chat with me. When the two of us were alone in the office, I asked her how she was doing. She started to tear up and said she was having a hard time. Monica shared that two weeks ago a young man had contacted her looking for help; he was 21 years old and was struggling with his addiction to injection drugs. He was desperate for help as he had a baby and a girlfriend that he was not able to see due to his drug use. Monica said she had been talking with him every day trying to get him some resources and listening to what he had to say. She said she really wanted to help him get his life back on track. The following weekend, this young man died of a drug overdose. Monica started crying as she told me this and I could see the regret and despair in her face knowing that she could not help him. It was clear to me that she felt some responsibility for his death.

Prior to this incident, The 595 Prevention Team Inc. (The 595) submitted a proposal to the Canadian Institute of Health Research (CIHR). The proposal, which will be discussed throughout this paper, was a project that would explore *what goes around* within the social networks of The 595 Peers; specifically, how Peers work to keep their communities safe. The project was built on the definition of harm reduction.

² A Peer is an individual who self identifies as a member of an affected community and has/is working in a formal or informal peer support capacity to reduce the rates of hepatitis C, human immunodeficiency virus and sexually transmitted infections.

³ This individual has been provided a pseudonym to protect her identify.

Harm Reduction is a set of strategies and tactics that encourage people to reduce harm to themselves and their communities, through the sharing of relevant information, facts and practical material tools, that will allow them to make informed and educated decisions. It recognizes the competency of their efforts to protect themselves, their loved ones and their communities.

Health Canada, 2002, p. 26

People who use drugs are invested in protecting their loved ones and their communities. As the definition states, individuals will share information and tools in an attempt to keep their community safe. In Monica's case, she had only known this young man for a week. Yet, when he died, she carried the burden of feeling as though she did not do enough to save him. She felt that she should have put more effort into trying to prevent his death.

Let me share what Monica's investment in her community truly looks like.

Monica runs a peer-based organization that provides supports to individuals that use drugs, particularly injection drugs. She has been running this organization for many years without funding and on a completely volunteer basis. When the incident occurred, Monica was undergoing treatment for a life threatening illness. She was waking up every day feeling sick and in pain, yet she answered the phone when this young man called. She never told him that she was sick and not in any condition to help him. Rather, Monica started working to find him resources, making phone calls on his behalf, and spending hours on the phone with him listening to what he was going through; all of this while she was ill.

When Monica left my office that afternoon, I sat down and thought of what she had just shared with me. I had been working in the field of harm reduction with

individuals that use drugs and are street-involved since 2002. As I was reflecting, for the first time I truly understood what the definition of harm reduction really meant.

1.2 Personal Involvement in the Research

As the executive director of The 595 and a graduate student at the University of Manitoba, my involvement in the research described in this paper had two purposes. In the fall of 2007, I began the Masters of Science, Family Social Sciences program at the University of Manitoba. In 2011, as The 595's executive director I submitted a proposal to CIHR as the "nominated principle applicant." I received the grant which included a proposed pilot project titled *What Goes Around: How Peers Use their Social Networks to Share STBBI Education and Information*. As the executive director, I was responsible for the research including developing research tools, conducting interviews, completing data analysis, and preparing final reports. In consultation with my academic advisor, Dr. Javier Mignone (University of Manitoba), it was decided that, in collaboration with The 595 Peer Working Group (595PWG), this pilot project would serve as my Master's thesis.

1.3 The Prevalence of HIV, Hepatitis C, and STIs in Manitoba.

Each year, many Manitobans are affected by sexual transmitted and blood borne infections (STBBI). There are many STBBI including chlamydia, gonorrhea, syphilis, human immunodeficiency virus (HIV), and hepatitis C. Rates of some of these STBBI are on the rise. In the past ten years, "there has been a substantial increase in reported rates of chlamydia and gonorrhea, particularly chlamydia" (Manitoba Health, 2011,

p.133). In 2011 in Manitoba, there were 6815 cases of Chlamydia, 1074 cases of gonorrhea and 469 cases of gonorrhea and chlamydia co-infections. Additionally, there were 58 cases of syphilis reported (Manitoba Health, 2011).

HIV is a virus that attacks the immune system (Public Health Agency of Canada, 2011). Without medication, the immune system fails and individuals progress to acquired immune deficiency syndrome (AIDS). The virus is transmitted through semen, vaginal fluids, anal fluid, blood, and breast milk. There is no cure for HIV but with treatment, individuals can live a long life. However, AIDS is often fatal if not treated. There were 80 new HIV cases in care in 2011, 102 in 2010, and 99 in 2009 (Manitoba HIV Program, 2010, 2011). The Manitoba HIV Program (2011) reports that although new HIV infections have stabilized in Canada since 2002, new HIV infections are increasing in Manitoba. Furthermore, the rate of new cases in Manitoba (12.3 per 100,000) is higher than the national average (8.2 per 100,000). Also notable is the unique mode of HIV transmission in the province. While men who have sex with men is the leading mode for transmission in Canada, in Manitoba the leading mode is heterosexual sex (67%) followed by men having sex with men (18%), and intravenous drug use (11%).

Hepatitis C is a virus transmitted in the blood that causes chronic liver disease (Public Health Agency of Canada, 2011). In 2011 there were 317 new cases of hepatitis C in Manitoba (Manitoba Health, 2011). The virus is transmitted when infected blood enters the blood stream of another individual. This can occur when unsterile equipment or techniques are used during tattooing, body piercing, and acupuncture. It can also be transmitted when sharing particular items with someone who is positive for hepatitis C, such as drug use equipment (e.g. injection equipment and snorting straws) or personal

hygiene equipment (e.g. razors, nail clippers, toothbrush). Before 1992, some individuals contacted hepatitis C through blood transfusions, blood products, and organ transplants. Hepatitis C is not sexually transmitted; however, it may be transmitted during sexual activity that involves blood-to-blood contact. According to Public Health Agency of Canada (2011), hepatitis C is treatable and in some cases individuals can be cured.

It is important to recognize that there are conditions that increase the vulnerability of particular populations with regards to acquiring STBBI. In Canada, men who have sex with men represent the highest number of persons living with HIV (Public Health Agency of Canada, 2011). This group continues to be at risk for transmission due to the biology of HIV transmission through unprotected anal sex. According to Joint United Nations Program on HIV/AIDS (UNAIDS, 2002) those involved in sex work have higher rates of HIV infections when compared to other populations within a country. UNAIDS define sex work as, “female, male and transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally, and who may or may not consciously define those activities as income-generating.” Larkin (2000) stated that due to the lack of economic resources and gender inequalities, some women and trans-women are forced into *survival sex*: “the exchange of sex acts for money or in order to meet needs” (Jalloh, 2011, p.65) such as food, shelter, or other material goods. It is important to note that many of the individuals engaged in sex work also use drugs (Connors, 1996; Larkin, 2000 & McIntyre, 2007), which increases routes of transmission. In particular, during injection drug use the sharing of needles or equipment used for preparing drugs can increase risk for transmission of hepatitis C and HIV.

1.4 The 595 Prevention Team Inc.

Being a Peer, “it’s about being non-judgmental and accepting others and providing support.” -595 Peer

The 595, formerly known as the Manitoba Harm Reduction Network, is a network of over 100 member organizations interested in addressing the determinants of health and preventing the transmission of STBBI, primarily HIV and hepatitis C, in Manitoba. The mandate of The 595 is to work with Peers, network members, policy makers, and community leaders to make recommendations regarding the development, implementation, and evaluation of initiatives rooted in the principles of harm reduction.

The 595 has five strategic priorities that guide their work (The 595, 2011):

1. Welcoming peer input and meaningful peer involvement.
2. Increasing the promotion and education of resources rooted in principles of harm reduction for peers and professionals in Manitoba.
3. Increasing access to services, materials, and resources to those in need.
4. Broadly integrating the philosophy of evidence-based practice in STBBI strategies.
5. Marketing The 595 Prevention Team.

The first priority is *welcoming Peer input and meaningful Peer involvement*.

The 595 believes that peers are the experts in STBBI prevention, treatment, and care.

“Nothing about us without us!” (Canadian HIV/AIDS Legal Network, 2005) is

a slogan used to communicate the guiding principle that policies and programs should not be developed without the full participation of members of the group(s) affected by that policy. This involves individuals that are often marginalized from political, social, and economic opportunities. The 595 aims to support peers in all

aspects of planning and implementation of harm reduction programs and believes that peer involvement should be a priority of any harm reduction based approach.

Within the context of this paper, a Peer is an individual who self identifies as a member of an affected community and is working to reduce the transmission of STBBI (The 595 PWG Handbook, 2011). A Peer is infected, affected, or at risk for STBBI. This includes individuals that are impacted by the social determinants of health, the “factors that influence our choices and our ability to make changes in our lives” (Manitoba Health, 2011, p.xiii). This then translates to individuals that are engaged in drug use, sex work, and other high-risk activities in which STBBI can be transmitted. The 595 has many mechanisms in which they engage Peers including the 595 Peer Working Group, community based research projects, a drop in volunteer program, and the Peer Secretariat Project (a program that supports peer-based organizations).

1.5 The 595 Peer Working Group

The 595PWG is an advisory group of The 595 that is made up of 20 Peers. This group gives Peers an opportunity to discuss ideas around harm reduction and inform the programs that provide services to them. The 595PWG believes that employing a harm reduction approach is the best way to support underserved populations and reduce STBBI in Manitoba. Further, the 595PWG believes that if organizations use this model they will be better able to address and support their participants’/ clients’ needs.

Within The 595, Peers participate on the coordinating committee (the governing body of The 595), the policy and practice task group, the education and communication task group, and most ad hoc groups. Additionally, Peers assist in facilitating workshops

and presentations on harm reduction, working with individuals that use drugs, and individuals with HIV and hepatitis C. The Peers participate in many events around the province to promote The 595 and STBBI prevention strategies including World Hepatitis Day, World AIDS Day, Transgender Day of Remembrance, and Pride Winnipeg Festival. The 595PWG also attend many training opportunities throughout the year including workshops and conferences that they determine are relevant to them. Further, support is provided to ensure Peers participate on coalitions and working groups outside of The 595, such as the Sexually Exploited Youth Community Coalition and various boards.

Most important and relevant to this paper is the engagement of the 595PWG in community based research. The Peers have embarked on two previous research projects; *“Hell Yeah I’m an Expert!”* (2008 to 2009) and *“DIY distribution: Peer directed harm reduction supply distribution!”* (2009-2010). Through these projects, the 595PWG has increased their capacity to initiate, direct, and participate in research about them that will impact them.

1.6 Project Design

1.6.1. Canadian Institute of Health Research (CIHR)

The research described in the paper is a pilot project of a larger catalyst grant that has been funded by the CIHR. The larger catalyst grant has four objectives.

1. Strengthen the partnership between community members, community organizations, and the University of Manitoba. The goal is to develop a comprehensive model of working with community to conduct research that adheres to the principles of community based research.

2. Increase research capacity involving community members. Community members will be part of the research team, receive appropriate training and share their own expertise in matters of accessing the community, appropriate areas of inquiry, ethical concerns and dissemination.
3. To conduct a pilot project that describes the processes in which Peers share information, resources, and tools regarding STBBI prevention in their social networks.
4. To develop a more comprehensive community based research proposal based on information gathered through the pilot.

This paper focused on objective three. A committee was established to help achieve the objectives listed above. The CIHR committee included Shohan Illsley (Executive Director, The 595), Dr. Javier Mignone (Faculty of Human Ecology, University of Manitoba), Dr. John Wylie (Community Health Sciences, University of Manitoba), Paula Migliardi (Family Social Sciences, University of Manitoba), Chelsea Jalloh (Research Coordinator, The 595), Debbie Stewart (Peer Researcher, The 595), and Ethan West (Peer Researcher, The 595).

1.6.2 The principles of community based research

The initial concept for this research was conceived by the 595PWG following a presentation of the previous community based research (CBR) project they were engaged in. The initial concept for this research was presented as a case study at the *Summer Institute at the University of Regina: Community Based Health Research* in June 2011. A group of students and community members, including a member of the 595PWG,

engaged in a discussion of the principles that formulate CBR and the influence of these principles on this research project. CBR complements the values of The 595; “a fundamental characteristic of community-based research as defined here is the emphasis on the participation and influence of nonacademic researchers in the process of creating knowledge” (Israel, Schulz, Parker, & Becker, 1998, p. 177). The principles of CBR that guided the research are as follows (Minkler & Wallerstein, 2003, p. 8):

1. *It was participatory:* This model of community engagement ensured that the 595PWG members created, participated in, and had control over the direction of the research.
2. *It was cooperative, engaging community members and researchers in a joint process in which both contributed equally:* This model required negotiating with all stakeholders to develop consensus on research goals, objectives, and activities.
3. *It was a co-learning process:* This model allowed for a balance between academic and community relevance and all stakeholders involved gained new knowledge from one another.
4. *It involved systems development and local community capacity building:* This model recognized that community already had capacity and worked to build on it. The 595PWG received training in research methods, ethics protocols, data analysis and interpretation, and dissemination.
5. *It was an empowering process through which participants increased control over their lives:* This model allowed for the 595PWG to take a lead in

research that affects their everyday lives. The research results included implications for programming at organizations that serve the Peers.

6. *It achieved a balance between research and action:* This model engaged stakeholders in conducting research as well as disseminating the findings. It allowed for multiple dissemination tools to reach targeted audiences, which may further influence action.

1.6.3 Previous community based research projects

From 2008 to 2009, the 595PWG embarked on their first CBR project titled, *“Hell Yeah I’m an Expert: A snapshot of peer engagement in HIV/AIDS, STI’s and BBP prevention initiatives.”* The goal of this research was to explore the ways in which Peer voices could be better heard in the context of STBBI prevention, care and support. The key questions were:

1. How do Peers participate in community organizations, programs, networks, and government committees?
2. What are the best things about being a Peer in organizations, programs, networks, and government committees? What are the things that make Peer participation work?
3. What are the things Peers do not like about participating in organizations, programs, networks, and government committees? What barriers do Peers face when it comes to participation?
4. What can be changed to better include Peers in health and social services?

The results of this project identified the need to nurture and support peer based organizations (PBOs) that are working to empower and provide services to those that are infected or affected by HIV/ hepatitis C. The PBOs are running on either fundraising efforts or volunteer time. Due to this constraint, it is apparent that the scope of work that could be done is hindered. It is important to note that individuals that are living with HIV or hepatitis C are doing the work and, at times, they struggle with their health. This speaks to the dedication and commitment that is often behind the work.

In 2008, as an outcome of this research, The 595 received funds to establish a comprehensive Peer Secretariat Project (PSP) that involves working with PBOs to provide administrative support and build on the capacity of their members. The 595 supports these organizations in developing evaluation plans, assisting with proposal writing, and developing work plans. The 595 currently partners with eight PBOs including the 595PWG, the Manitoba Hepatitis C Support Community Inc., Manitoba Area Network of Drug Users, AYO! Aboriginal Youth Opportunities, Two-Spirited People of Manitoba Inc., the Women's Advisory Council for the Mothering Project (Mount Carmel Clinic), the Anti-Violence Advisory Team of Sage House (Mount Carmel Clinic), and the Newcomer Women's Group (Sexuality Education Resource Centre).

In 2009 to 2010, the 595PWG embarked on their second CBR project titled, "*DIY distribution: Peer directed harm reduction supply distribution.*" This project investigated the process of Peers creating and administering a harm reduction supply site for their peers. Four peer researchers from the 595PWG were recruited and trained. They were responsible for identifying training needs, designing the distribution site, and providing education and information for their peers. For various reasons, including the nature of a

pilot project, the only form of advertising was word of mouth by the peer researchers. A highlight of the project was that new people started accessing supplies at the distribution site. This suggested that the peer researchers themselves and those that were accessing the service were informing their social networks about the site. This coincides with research that suggests that peer-driven interventions reach a larger and more diverse set of drug users (Broadhead, Heckathorn, Weakliem, et al, 1998).

Another emerging theme of this study was the *informal* delivery of prevention information by Peers. After discussing the research with the 595PWG, members of the group indicated that the information that service providers teach them regarding STBBI prevention and treatment is passed on within their community. Again, this idea is supported by existing research. A recent study in the United States looked at peer-based information sharing and found that after a “peer” shared information with a community member, it was possible for “secondary distribution” to take place when that community member shared the information with his own network (Weeks, Dickson-Gomez, Mosac, Convey, Martinez, & Clair, 2009). A better understanding of how to capitalize on the informal spread of harm reduction information throughout a community could have significant implications on STBBI in Manitoba. In this case, the 595PWG indicated that they would like to demonstrate that they do share their knowledge to keep their community safe. The 595PWG stated that they would like service providers to employ them more effectively and efficiently to get the necessary information communicated to those that service providers do not have access to.

1.6.4 Guiding research questions

As noted previously, the last line in the definition of harm reduction is what this research would like to further explore, the idea that, “[harm reduction] recognizes the competency of [people’s] efforts to protect themselves, their loved ones and their communities” (Health Canada, 2011). The definition recognizes that Peers are working to keep themselves and their communities safe. At the conclusion of the previous research project, the 595PWG indicated that they wanted to show service providers that they are invested in keeping their community safe and that they have access to the most entrenched individuals to pass on the information that is necessary. The current project, *“What Goes Around: How Peers Use Their Social Networks to Share STBBI Education and Information”* was then developed. The guiding questions for this research were:

1. To what extent do the 595PWG members share STBBI prevention information with one another?
2. What information is being shared?
3. Who is it being shared with?
4. How do they share this information? Under what conditions is information shared?
5. Why do they share information?
6. Is there information that they are receiving that they do not share? What are the barriers to sharing some information?

The 595 believes that this project will shed light on effective ways to pass information to peers, information that is crucial to STBBI prevention. This new

knowledge will be shared with stakeholders in STBBI prevention and treatment and is intended as a catalyst for improvement in program development and implementation. The 595PWG will participate in developing a knowledge translation strategy to communicate outcomes with community members, community-based organizations, policy and decision-makers, and other researchers.

Chapter Two - Literature review

2.1 An Overview of Harm Reduction

As previously defined in Chapter 1, harm reduction is a set of practical strategies that can be used to meet people “where they are at” in regards to their engagement in behaviors that increase risk for STBBI transmission. By definition, harm reduction implies that there are tactics to prevent the transmission of STBBI and other related harms while people are still engaging in those behaviours, particularly drug use and sex. The extent to which individuals will promote harm reduction is evident among the Peers; even when people are sick they are invested in keeping their community safe. During her interview, Monica reflected on the story that was introduced at the beginning of this paper. Here is what she had to say:

Shohan (interviewer): Monica you were doing all of this while you were going through chemo?

Monica: Yeah.

Shohan: So you were super sick yourself too right?

Monica: But I couldn't say very well, well I'm sick right now, which I did do. You know we shut [services] down basically, but there were some things... We still did what we could. Anything major there was no way I could, I didn't have the strength to do it.

Examples of harm reduction include the use of safer sex and safer drug use supplies during behaviours when STBBI can be transmitted. The following are some of the most commonly known examples of harm reduction:

- Using a condom when having penetrative sex

- Getting tested for STBBI
- Having a designated driver
- Choosing not to use drugs and alcohol together
- Using a new needle each time you inject your drugs

It is important to point out that harm reduction can also include abstinence. For many reasons, there is an ongoing discourse between abstinence and harm reduction, whereby these two are believed to be exclusive approaches. Harm reduction can take many forms including choosing to abstain from injection drug use to using new equipment each time you inject drugs. For service providers, harm reduction might involve advocating for your client with their social worker, providing education on how to prevent overdose, and ensuring that you meet your client where they are at.

There have been many principles of harm reduction identified in the research. The 595PWG has identified the following five principles as important to their working definition of harm reduction and these are the principles discussed during The 595's workshop, "*Harm Reduction 2.0: Beyond The Needle*" (Manitoba Harm Reduction Network, 2008).

1. *Common sense*: It is common sense that people will engage in risky behaviours. It is common sense that taking small steps in your health can make an improvement. It is also common sense that if people feel judged or alienated they will not seek medical care.
2. *Human dignity*: Everyone, no matter his or her choices or lifestyle, deserves to be treated with respect and has the right to access health care.

3. *Focus on harms*: This looks at the systems and policies that may be harmful. It also looks at the behaviours themselves. Instead of just saying “drugs are dangerous,” we need to ask, “what about drugs can be dangerous?” and then “how can we address those dangers?”
4. *Balance*: Making sure the needs of a certain group are balanced with the needs of the larger community. Balance demands engagement of affected communities in the development of agendas.
5. *Dealing with priority issues*: Dealing with the priority issues of your clients, even if you do not agree that they should be the priority.

To illustrate the principles, let us consider Rebecca’s⁴ story. For many years, Rebecca was entrenched in the streets, which included sex work and a crack addiction. Rebecca had two older children that were in the custody of Child and Family Services when she discovered she was pregnant again. Rebecca made the decision to deal with her addiction and find herself an apartment. To stop smoking crack, Rebecca started to smoke marijuana instead. By the time she gave birth, her consumption of marijuana was limited to a “joint” (a marijuana smoke) in the morning and another in the evening. Rebecca took her baby home where she maintained her abstinence from crack and kept her apartment for two years. Due to her success, her social worker planned to return Rebecca’s 12 year old daughter to her. Rebecca was thrilled but was also adamant that she did not want her daughter to see her smoking marijuana, so she quit. Within two months, Rebecca returned to smoking crack and engaging in sex work. She was behind on all her bills and was at risk of losing her apartment and custody of her children. It took another two months for

⁴ Rebecca is a pseudonym given to a previous participant of The 595.

Rebecca to get into treatment for her addiction and when she was able to maintain custody of her children Rebecca stated, “I realized I have to continue to smoke marijuana until I could deal with my issues.”

Harm reduction and non-judgmental approaches are about taking the lens off the client and turning it back towards the health care provider, agency, or government to assess systemic barriers that make getting care or service difficult for people. Harm reduction approaches are evidence-based, are rooted in research and evaluation, and are community-based. Harm reduction approaches create success by broadening the scope of options for clients who are trying to stay as healthy as possible. As stated in the Chief Provincial Public Health Officer’s Report on the Health Status of Manitobans 2010, “Both STIs [sexually transmitted infections] and BBP [blood borne pathogens] are preventable through the use of safer personal practices such as safer sex, safer injection drug use and not sharing personal items such as toothbrushes and razors” (Manitoba Health, 2011, p.38). Harm reduction is important because it can reduce the spread of HIV and hepatitis C.

2.2 Safer Drug Use and Safer Sex Information

STBBI rates are a public health concern and, with some rates rising, innovative programming and policy changes to address this concern are imperative. All STBBI were reported by Manitoba Health (2011) throughout the province including Winnipeg, rural Manitoba and First Nations Communities. STBBI are transmitted primarily through sex and drug use, which makes safer sex and safer drug use information integral to the prevention of these infections. Safer sex and safer drug use messages are provided to the

general public as well as those at risk through various mechanisms. These messages can be delivered formally through teachers, nurses, doctors, pamphlets, and public campaigns. This information can also be delivered through informal sources such as friends and family members.

Access to safer drug use and safer sex information is critical to prevent the spread of STBBI within and between drug using networks (Trealoar & Abelson, 2005; Latkin, 1998). Safer drug use information includes messages of not sharing any of your drug equipment including needles, cookers (the containers where drugs are heated up), filters, water, and tourniquets as well as knowing where to access new drug equipment. Safer sex information includes messages of using barriers during sexual activity (condoms, dental dams) and getting tested and treated for STBBI. Service providers that work from a harm reduction philosophy provide their clients with safer drug use and safer sex education; in some cases, clients can also access safer drug use and safer sex equipment. Equipment can include condoms, lubrication, needles, crack pipes, and other drug use equipment.

Claire (1995) found that during the initiation of injecting drugs, service providers are not there to teach safer drug use. Rather, initiation is often done with a peer that has some experience injecting drugs (as cited in Treloar & Ableson, 2005). This would suggest that informal sources of information are crucial in preventing the spread of STBBI. It also suggests that those who are more experienced at injecting drugs need to have accurate information, as well as effective communication skills, in order to pass that information on. Service providers often have access to the more experienced injectors (those that have been injecting drugs for some time) when they access services for treatment of STBBI or health concerns related to injecting drugs such as abscesses.

Service providers offer them information on safer sex and safer drug use in the hopes of preventing further infections or transmission of their infection.

2.3 Peer Delivery of Information

2.3.1 Peers as a source of safer drug use and safer sex information

Due to the stigma attached with several of the activities that may result in the transmission of STBBI (notably sex work and injection drug use), it is not uncommon that individuals who engage in these activities have had negative experiences within the health care system and with service providers. Mistrust is particularly bred among a “population with limited resources and ample reasons to mistrust authority figures” (Sylvestre & Zweben, 2007, p.408). Clearly, this creates a barrier to the exchange of harm reduction information that is not present when information is exchanged among peers. It is important to note that drug use does not indicate that an individual is not concerned about or invested in their health and well-being (Sylvestre & Zweben, 2007, p, 409). Rather, Friedman et. al. (2007) reported that individuals who use drugs are concerned about their own wellbeing as well as their communities.

Research has found that the peer group is the natural source of information, particularly for individuals that inject drugs (Treloar & Abelson, 2005). Furthermore, one study has found that knowledge about hepatitis C prevention including needle sharing, and safer injecting is most effective when delivered through a peer education intervention (Garfein et al., 2007). Latkin and colleagues (2003) reported that 90% of their participants that were trained in HIV prevention indicated high levels of comfort in discussing prevention with family and friends. This is

contradictory to previous research, which reported a general unease with the subject matter, resulting in an unwillingness to discuss the subject, and relying on gossip and rumor (Smith et al., 1999). Latkin's research suggests that when peers are trained and given adequate knowledge, they are more likely to communicate prevention information to their personal networks.

Research shows that individuals that are infected with HIV or hepatitis C are more likely than individuals who are uninfected to pass on information to others that use injection drugs (Trealoar & Abelson, 2005, Latkin, 1998, Broadhead et al., 1998). "Positive prevention" is a term used for working with peers that are HIV positive to ensure they have the resources, knowledge, and tools to promote their own health and prevent transmission of the virus to others (Kalichman, 2005; Global Network of People Living with HIV/AIDS, 2009). Although there are some criticisms of positive prevention, it is a growing initiative in light of HIV positive individuals living longer, healthier lives.

2.3.2 Informal delivery of safer drug use and safer sex information

Existing literature often differentiates between formal and informal peer education. Formal peer education is often structured, includes selection criteria, intensive training, and may involve supervision of information dissemination and quality checks (Walker & Awis, 1999, p. 574). Informal peer education, on the other hand, may have limited peer selection criteria, basic training, and take place without an element of supervision for information dissemination (Walker & Awis, 1999, p. 574). However, a common thread between the two approaches is an inherent sense of

peer responsibility and the motivation to prevent community, children, and family members from becoming infected (Treloar & Abelson, 2005; Latkin, 1998).

To date, most research that discusses peer-based information sharing involves information about formal approaches of sharing information (Sylvestre & Zweben, 2007; Treloar & Abelson, 2005; Broadhead et al., 1998). This includes recruiting, training, and supporting peer leaders in delivering STBBI prevention education within their networks. While still quite novel, the use of a peer-based approach to the development and delivery of STBBI prevention programming is gaining popularity within organizations. Existing research in this area indicates it is an effective approach to engage, educate, and treat the most entrenched individuals (Sylvestre & Zweben, 2007; Garfein et al., 2007; Latkin, et al, 2003; Broadhead et al., 1998; Latkin, 1998; Weeks et al, 2006). While criticisms of programs that rely on peer-based education do exist, many of these criticisms are related to poor process and an inefficient structure to support this type of initiative (lack of clear project objectives, inadequate training and support for peer-educators, lack of skilled personnel to manage the complex process of peer education) (Walker & Avis, 1999).

Treloar and Abelson (2005) explored how STBBI prevention information is exchanged within injection drug networks using peer education in Australia. Formal information sources included pamphlets, needle and syringe programs, youth services, drug treatment venues, doctors and nurses, and school teachers. Informal information sources included partner, family, schoolmates, workmates, club buddies, friends, acquaintance, and dealers (Treloar & Abelson, 2005). This research found that the most common source of formal information about hepatitis C and safer injecting practices, as reported by participants, were pamphlets (64%), needle syringe programs (63%), and

doctors or nurses (34%). When looking at informal sources of information, the researchers found that friends (47%) accounted for a large portion of where participants received their information, followed by acquaintances (21%), partners (16%), family (14%), club buddies (11%), dealers (8%) and other sources (8%). Interestingly, 89% of participants stated they used formal information sources in combination with informal sources, while 10% stated they relied exclusively on informal sources of information. Although pamphlets and needle syringe programs were the most frequently identified sources of information, “friends” were identified by almost half of all respondents as a source of information.

The researchers went on to look at the process of information exchange in more detail; what they found was that 55% of participants reported passing on information to others that inject drugs. Interestingly, when the researchers controlled for smaller communities, the participants reported higher rates of passing on information. The participants reported passing on the following information with their peers: information about needle disposal (48%), needle syringe programs (46%), hepatitis C (35%), HIV (30%), the law (25%), and Hepatitis B (22%). In addition to the above, other safe drug use information was passed on including risk of injecting into hands, adverse effects of drugs, information about filtering your drugs, abscesses, and risk for addiction. Another interesting finding is that participants who reported actively seeking out STBBI testing had a higher knowledge of blood borne viruses and safe injecting practices to share (Treloar & Abelson, 2005, p.51). This might suggest that connecting with health care providers, even when one is not necessarily seeking harm reduction information, may result in learning more about harm reduction practices.

Trealor and Abelson (2005) have demonstrated that information exchange between individuals who inject drugs is common. Half of the sample (sample size was 336 individuals) stated they received some information from their friends which are informal sources of information, and over half of the sample said they pass information on to others that inject drugs; they themselves are now an informal source of information for others.

However, what this study did not explore was, *how* the information is being passed on and the specifics of *who* it is being passed to and under what circumstances. Further, while Trealor and Abelson's study concludes that information exchange between individuals that inject drugs is quite common, "the quality of that information [being exchanged] is currently unknown" (2005, p.52). The 595's research wanted to explore some of these issues and ask questions, such as, when information and tools are given to peers what do they do with them? Do they adapt messages based on who they are providing it to? Is the information that is being passed along factual and accurate? What are the barriers to passing on some messages? Is there anyone peers prefer not to share harm reduction messages with?

These questions that arise from the results of the Trealor and Abelson study have had a direct impact in shaping the guiding research questions for this project. As noted at the end of the Chapter 1, this project explored the context under which the 595PWG shares information on STBBI prevention within their informal networks. This project helped to fill knowledge gaps regarding the specific circumstances that facilitate, or get in the way of, fulfilling such responsibility.

Chapter Three - Methodology

3.1 Qualitative Research Design

This CBR project was conducted in Winnipeg, Manitoba, at The 595 office on Broadway Ave. This is qualitative research that, by nature of a CBR project, has two purposes and therefore two types of research are being conducted simultaneously; basic research and action research (Patton, 2002). The first purpose of this “basic research” is to contribute to academic knowledge and support existing theory. As noted in Chapter 2, there is limited research on the informal sharing of safer drug use and safer sex information. This project will explain the processes involved and contribute general knowledge on how information is shared informally. Steps have been taken to ensure academic requirements have been met which included a formal presentation of the research proposal, development of an academic committee, acquiring ethics approval, data collection and analysis, and this paper that will be submitted to the Faculty of Graduate Studies at the University of Manitoba with the hopes of future publication. The audience for this basic research is the academic community. The second purpose of this “action research” is to “explicitly and purposefully become part of the change process by engaging the people in the program or organization in studying their own problems in order to solve those problems” (Whyte, 1989, as cited in Patton, 2002). As noted by Patton, “the distinction between research and action becomes quite blurred and the research methods tend to be less systematic and more informal and quite specific to the problem, people, and organizations for which the research is undertaken” (p. 221). Further, Patton states, “design and data collection tend to be more informal, the people in the situation are often directly involved in gathering the information and then studying

themselves” (p. 221). Seen below, this is precisely what has transpired in this CBR project. The results of the study are expected to be used to make improvements to existing programing as well as to inform future program development. There are many intended audiences for this action research and therefore there will be various dissemination tools developed. For example, a PowerPoint presentation will be developed and delivered to executive directors and policy makers at targeted organizations in Winnipeg. Furthermore, the 595PWG will develop a dissemination tool to present their results. This is still to be determined and may be a quilt, paints, or photographic installation. The 595PWG will then present their tool(s) at various conferences and forums throughout Manitoba and Canada.

3.2 Ethical Considerations

Ethics approval was obtained from the Joint Faculty Research Ethics Board at the University of Manitoba (Appendix A). All data collected (transcribed documents and structured questionnaires) is stored at The 595 office in a locked storage cabinet and on a password protected computer.

As stated in Chapter 1, the researcher holds the position of executive director at The 595. Due to her skill set and expertise regarding the research subject matter, it was important that she conduct the interviews. This can be problematic particularly in the following two areas: 1. due to power dynamics, the participants may feel coerced or forced to participate; and 2. participants may respond more positively to the research questions than they would have if interviewed by someone else. To minimize the impact of these potential problems, it was important first to recognize that this is a CBR project

that the 595PWG themselves developed. The interview questions were first posed by the participants following their last CBR project. The executive director had been involved throughout the process of previous projects, and the participants assumed that she would be involved in this research initiative.

To address this ethical dilemma, the 595 project coordinator, a staff member who is not involved in the research, was asked to facilitate a discussion with the 595PWG. The following two steps were taken to problem solve this dilemma. First, the project coordinator presented the issues to the participants on the 595PWG Facebook (a private page only accessible by the 595PWG members). Appendix B is the script that was posted on the Facebook page to introduce the dilemma and initiate discussion. The executive director does not have access to the Facebook page. Second, the dilemma was presented at a 595PWG meeting in September 2012. The executive director was not present at the meeting. In attendance were the project coordinator who facilitated the discussion and the research collaborator who addressed any questions related to the research or ethics. Participants were aware that the executive director would not be privy to who said what during the discussion. The benefits and risks of having the interviews conducted by either the executive director or a third party were identified and discussed. Additionally, participants were made aware that the executive director would be reading all transcripts and it was possible that she would be able to identify individuals based on what they said or how they said it. A vote took place at the meeting and a summary of the discussion was provided to the executive director by the research collaborator and the project coordinator. The consensus of the group was that there should be multiple options about

how to be interviewed, which included by the executive director. This will be discussed further below.

3.3 Recruitment Process

After reviewing the summary notes, a recruitment process (Appendix C) was developed by the executive director and the research coordinator and approved by the 595PWG. Participants were given four options for the interviews; 1. they could choose not to be interviewed, 2. they could choose to be interviewed by the executive director, 3. they could choose to be interviewed by the executive director and the research coordinator, or 4. they could choose to be interviewed by the research coordinator only. After indicating their preference, the participants were then asked to contact the project coordinator in order to book their interview date and time.

3.4 Interviews

Seventeen face-to-face interviews were conducted and audio recorded with the participants between December 2012 and February 2013. Interviews took place at The 595 office on Broadway Avenue in Winnipeg. Snack foods and beverages were provided. Prior to each interview being conducted, participants drew a random alias out of a bowl. Following data interpretation, one Peer stated that he felt safer disclosing information under a pseudonym. He stated having a pseudonym helped him return to a place where he related to people while under the influence. This alias was used for participants' interviews, the subsequent transcript, and in the analysis and write-up. Care was taken to ensure that the alias name corresponded with the participant's gender identity. Only the

executive director had a master list indicating which participant corresponded to which code name. Participants were informed that it was not imperative for them to remember their alias, but they could make a note of it if they wanted to. The structured questionnaire was administered at the end of the interview. The interviews ranged from 20 minutes to 60 minutes in length and following each interview, the participants received a \$20 honorarium for their time and two bus tickets. In May 2013, during a CBR meeting, the follow up questionnaire was administered.

The interviewer(s) recorded notes on a paper throughout the interview. The recordings were transcribed and erased upon verification of the transcripts. The voice recorder on an iPhone was used to record the interviews. When attempting to save one of the interviews, it was lost. Steps were taken to try to recover the interview but they were unsuccessful. Additionally, the last interview that was conducted was approximately 55 minutes in length and unfortunately only the first eight minutes were recorded. Unknown to the interviewer, there was a limited amount of space available on the iPhone and when space ran out, the rest of the interview was not recorded. For these two interviews, the interview notes that were written were used in the data analysis. With that said, there were limits in writing down notes and some important information may have been lost. For the second “lost” interview, it was helpful that a second interviewer was present, and we had two sets of interview notes for the data analysis.

3.5 Research Tools

All research tools were developed in collaboration with the participants and the academic committee. The following tools were developed and administered in this research.

3.5.1 Consent form

The original body of the consent form (Appendix D) was drafted by the researcher and presented to the participants at a CBR meeting. Feedback was solicited from the group and changes were made accordingly. Changes included simplifying language, clarification about provision of honoraria and bus tickets, and relevant support phone numbers to include. It is important to note that when a participant asked if he would receive the honoraria if he decided not to participate after five minutes of the interview, some of the other members of the group reminded him that this is *their* research and that his input and information is valuable. One member then told him that he had such a wealth of information on the topic that his participation would be as important as everyone else's (however, it continued to be stated that participation was completely voluntary).

When the section "*What are the risks of being part of this project?*" was discussed, the researcher stated that this section should include a list of the resources that participants already utilize. The list was intended to provide avenues of support should a participant feel that the interview brought up any feelings that he or she would like to debrief. The participants concluded that creating an exhaustive list of resources and supports that they access would be too many to include on the form. They suggested the list include the three most utilized organizations. In addition, there would be an option for

the participants to add contact information for their specific resources when the consent form was completed at the interview (*Figure 3.1*).

Figure 3.1 Excerpt From Consent Form

<p>WHAT ARE THE RISKS OF BEING PART OF THIS PROJECT?</p> <p>Taking part in the project should not put you at risk for physical harm. If after your interview you feel upset and need to talk to someone, please feel free to contact any of the following:</p> <p>Klinic Community Health Centre Crisis Line- 204-786-8686 Nine Circles Community Health Centre- 204-940-6000 Sage House – 204-943-6379</p> <p>If you already have someone you talk to, I would be happy to make sure you have his or her contact information before you leave.</p> <hr/>
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3.5.2 Interview guide

The interview guide (Appendix E) was developed by the 595PWG at a CBR meeting and in collaboration with the research team. The guide consisted of the following seven questions:

1. What do you consider to be key information on drug use that people should know?
2. Do you share safer drug use information with anyone?
3. What do you consider to be key information on sex that people should know?
4. Do you share safer sex information with anyone?
5. Do you adapt or change how you share information based on who you are sharing with?
6. When or why did you start sharing information?

7. Is there anything else you would like to say in this interview?

The 595PWG developed four of the questions which reflect the “who”, “what”, “when” and “where” of sharing safer drug use and safer sex information (Questions 2, 4, 5, & 6). Question five explores how people might adapt messages based on who they are sharing information with. Question six was suggested to support the definition of harm reduction.

After consulting with the participants, the researcher presented the interview guide to her thesis advisory committee for feedback. During that meeting, it was highlighted that it would be important to include what the participants identified as key information of safer drug use and safer sex practices. The advisory committee was hopeful that this would capture key messages that participants are aware of that they do *not* pass on. Questions one and three were added to capture this.

It is important to note that this document was only used as a guide. When interviewing the participants, the researcher was aware that the conversations could go in many different directions, many of which would be relevant to the research questions. It is also important to note that “prompts” were not added in the guide. For example, when asked who they share with, the goal was to capture those they recall so that there could be some context added as to why and where they share.

3.5.3 Structured questionnaire

A structured questionnaire (Appendix F) was developed to characterize the participants. The researcher drafted the questionnaire from existing literature and, in collaboration with the participants and the academic committee, appropriate revisions

were made. It is important to note that all categories were identified by the participants. For example, when discussing the gender categories, it was important to the group that “pangender” be included as an option because a participant stated that this is how he identifies. “Other” was also included in many questions so that participants could choose a response in addition to the options that were presented. The areas covered in the questionnaire included socio-demographic information (gender, sexual identity, ethnicity, education, housing situation, income source), HIV/ hepatitis C status, mental health and involvement in community and community organizations.

The participants wanted to include as many prompts as possible to recall the extent of their community involvement. The prompts they identified were peer-based groups, organizations, coalitions, working groups and “other”. Other was provided in the event that the categories did not accurately capture a group. Note that a group they identified with may have fit into multiple categories (for example, involvement in Sunshine House may be considered an “organization” for some participants, while another might consider Sunshine House a “peer-based organization”) During data analysis, the different organizations/groups/coalitions were summarized by the name of the organization, and not stratified by type of group.

As a reflection of themes found in existing literature, notably the Treavor and Abelson (2005) study, a question was included asking participants where they receive their information about HIV and hepatitis C, safer drug use practices, and safer sex practices. This table included both the formal sources of information (e.g. pamphlets, doctors, nurses and needle supply programs) and informal sources of information (e.g.

partner, family, peers) identified in the literature. Participants then checked off all of the applicable sources of both formal and informal information.

3.5.4 Follow up questionnaire

Once data analysis began, it was clear that the research would benefit from some additional information from participants. One unique advantage to this model of research was that we were able to go back to the participants and discuss gaps in information and gather further data to better inform the research questions. In this case, there were two gaps in the information. The first was age of the participants (to help characterize the participant population) and the second was their drug history. This included age of debut with drugs (including solvents), current drug of choice, historical methods of drug use, and tracking the evolution of their drug use and alcohol use.

In order to capture some of this additional information, the participants were approached at a CBR meeting and asked to write a narrative response outlining their drug history (substances they have used and how they have used them). However, in compiling the participants' responses, it was evident that the diversity in responses did not lend themselves to analysis. As a result, a second quantitative questionnaire (Appendix G) was developed and given to participants to fill out. This included questions such as participants' age (needed to help characterize the population, this information was inadvertently left out of the first questionnaire), age of debut of drug/solvent use and alcohol use, and a more directive checklist where participants could specify their drug history and indicate method of drug use (snorted, swallowed, injected, smoked, or other). The results from this second questionnaire were incorporated into data analysis.

Figure 3.2 Drug use table from the follow up questionnaire

Drug Name	At what age did you start using it? How long did you use it?	How did you use it?				
		Smoke	Swallow	Snort	Inject	Other
Marijuana	14 yrs old-ongoing	X				
Heroin	21 – 26				X	

3.6 Characteristics of the 595PWG

3.6.1 Demographics of the 595PWG

Table 3.1 *Characteristics of the Participants*

Category		<i>N = 17</i>
Gender		
	Male	6
	Female	6
	Transgender	4
	Pangender	1
Age		
	30-39	1
	40-49	9
	50-59	5
	60-69	1
	No response	1
Sexual Identify		
	Heterosexual	8
	Gay	7
	Bisexual	1
	Other (unspecified)	1
Ethnicity		
	Aboriginal	12
	Caucasian	4
	Metis	1
Highest Level of Education		
	Some high school (between grades 9- 11)	8
	High school diploma	5
	Some post secondary	4
Current Housing Situation		
	Renting	16
	Squatting	1
Current Living Situation		
	Alone	7
	With roommate	5
	With Family	3
	Common Law	1
	Homeless	1
Source of income		
	Social Assistance	14
	Part time work	2
	Full time	1
	Pension	2
	Sex work	3

The 595PWG is comprised of 17 members. The participants are between 33 and 62 years of age with a mean age of 46.6 years. Six participants identified as male, six as female, four as transgender, and one as pangender. Pangender is defined as “a person whose gender identity is comprised of all or many gender expressions” (Green & Peterson, p.6, 2006). Transgender is defined as “an umbrella term for people whose gender identity and/or gender expression differs from the sex they were assigned at birth. Transgender people may identify as female-to-male (FTM) or male-to-female (MTF)” (The Lesbian, Gay, Bisexual, & Transgender Community Centre, <http://www.gaycenter.org>). It is important to note that the four transgender participants are transgender women (male-to-female). Eight of the participants identified as heterosexual, seven as gay, one as bisexual, and one as other (unspecified). It is important to note that two transgender women identified as gay, one as heterosexual, and one as other. However, this is not uncommon, and existing research suggests that one’s “sexual orientation varies and is not dependent on gender identity” (Green & Peterson, p.9, 2006).

The majority of the participants identified as Aboriginal (n=12), four as Caucasian, and one as Metis. The terms Aboriginal and First Nations were discussed at length and the 595PWG chose to use Aboriginal.

Eight of the participants have some high school education, while five completed high school, and four attended some post-secondary. The majority of the participants are renting (n=16) while one participant indicated “squatting” as their current housing situation. When looking at current living situation seven participants reported living alone, five with a roommate, three with family, one with a common law, and one reported

being homeless. We should note that whether or not a participant is a recipient of social assistance may influence the disclosure of their living situation. Social assistance is the common term used by the 595PWG for Employment and Income Assistance. If you are on social assistance and are living common law or with a spouse, your benefits are combined and therefore you receive less from social assistance. Many of the participants reported that, due to this, they often will report living with a roommate rather than a common law partner or spouse. As Heather explains, “Well there’s me and *name* because we don’t tell welfare [social assistance] we are a couple otherwise it will be less... we’d get cut off.”

When reporting on source of income, the majority of participants reported social assistance as their source of income (n=14). While three participants do not receive social assistance at all, four participants shared that they receive social assistance in addition to supplementary income. Second sources of income included part time work (n=1), sex work, (n=2), and pension (n=1). One participant stated two sources of income as part time work and sex work (n=1).

Table 3.2 *Self- Identified Health Conditions*

Health Condition	<i>N= 17</i>
HIV Only	6
Hepatitis C Only	2
Co-infected with HIV & Hepatitis C	5
Mental Health	4
None	5

The researchers recognize that there are multiple other health conditions that participants may have; Table 3.2 is not an exhaustive list of health conditions that the

participants face. As per the question and relevance to the research, these are the conditions that the participants identified as important when the group developed the questionnaire. It is also important to clarify that these are self-reported health conditions. That is, for HIV and hepatitis C, these are individuals that have been tested and have received positive results. Literature shows that many people are positive and not aware of their status. For instance, in 2005, Health Canada estimated that of the approximately 58,000 people in Canada with HIV, “approximately one-quarter of those with HIV infection were undiagnosed” (as cited in Manitoba Health, 2011, p.39). This can be due to many factors including how recently they have been tested.

This is also the case with undiagnosed mental health conditions. In relation to mental health, we do not know if this data reflects actual diagnosis from a medical professional, or self-reports of mental health. During member checking with the participants, the group helped clarify what they were thinking of when they used the term “mental health” (included in the glossary). It is important to note that, despite creating a group definition at a later date, individuals used their own personal definition when they answered this question. During member checking the definition of mental health was broadened to include addiction. Some individuals, who had not included “addiction” into their personal definition, reported that, based on this group definition, they would change their answer if asked again.

Twelve of the participants reported having one of the above health conditions while only five stated they had none of the above conditions. Six participants reported being HIV positive, two reported being hepatitis C positive, five reported being co-infected with HIV and hepatitis C, and four reported a mental health condition. Notable

in this data is that two of the participants have been cured of hepatitis C. One is categorized under “none” and the other is under “HIV only.” The latter is relevant because the analysis will show the individual who is HIV positive still identifies as hepatitis C positive to his loved ones to account for his medical appointments and medications. This is due to the stigma around HIV and therefore he does not want anyone to know he is HIV positive.

3.6.2 Participants experience with drugs/ solvents and alcohol

Table 3.3 *Average Age of Debut of Drugs/ Solvents and Alcohol*

	Average Age of Debut	Age Range
What age did you start doing drugs/ solvents?	13.2 years	7 – 21 years
What age did you start drinking alcohol?	11.5 years	5 – 17 years

In the follow-up questionnaire the participants were asked at what age had they started using drugs/solvents and at what age had they started drinking alcohol. When developing the category drugs/solvents, it was made clear by participants that solvents needed to be identified but in the same category as drugs, not separate. It is important to remember that this data was self-reported and was based purely on participant recall and willingness to share. All 17 participants indicated drug or solvent use and 13 indicated that they have tried quitting at some point, while two respondents had no answer and two had “n/a.” This may be interpreted in two ways. The first is that they had not tried to quit using substances and the second is that they were not able to stop for a period of time that

they would deem quitting. The participants reported a mean age of 13.2 years for debut with drugs or solvents. Age of debut ranged from seven to 21 years old.

The participants were then asked to list their current drug of choice. Six of the participants listed more than one drug of choice. Current drugs of choice included marijuana (n=4), crack (n=4), cocaine (n=4), alcohol (n=2), opiates (heroin and morphine) (n=2), and solvents (n=1). Six of the participants did not indicate a current drug of choice. This could mean three things: that they no longer identify with a drug of choice, that they were not comfortable disclosing their drug of choice, or that they did not understand the question.

With alcohol use, a mean age of debut at 11.5 years was reported, ranging between 5 to 17 years. All 17 of the participants indicated that they have used alcohol. It is notable that seven participants reported an earlier debut with drugs or solvents than with alcohol, with the earliest reported use being five years of age. It is interesting to note that this participant indicated that he/she did not try drugs or solvents until 18 years of age. This finding challenges the idea that alcohol is a “gateway” substance that often leads to subsequent drug use.

Table 3.4 *Self-Disclosure of Methods of Drug Use*

Methods of Drug Use	N=17
Inject	15
Snort	14
Smoke	12
Swallow	11
Other	2

Participants were then asked to indicate all methods in which they did their drugs over the years. Drawn from the second questionnaire, this data is important because the method(s) by which individuals use their drugs may influence the type of safer drug use information they share, and with whom. Fifteen of the participants have injected drugs, 14 reported snorting, 12 reported smoking, 11 reported swallowing, and two reported “other.”

Interestingly, all of our participants stated they have used alcohol, yet only two identified it as their drug of choice (note that we asked about drug of choice not substance of choice which may have excluded alcohol as a response for some participants). When asked if their alcohol use has been problematic at any time, eight indicated that it has been a problem (7 responded “yes”, while 1 responded “sometimes”).

3.6.3 Participants’ sources of safer drug use and safer sex information

In characterizing the sample, we wanted to identify where the participants received safer drug use and safer sex information. Participants were asked, “*Where did you get your information about HIV, Hepatitis C, Safer Drug Use, Safer Sex Practices?*” They were then supplied with a list of formal sources and informal sources of information and asked to check all that applied.

Table 3.5 *Sources of HIV, Hepatitis C, Safer Drug Use, and Safer Sex Practices as Identified by Participants*

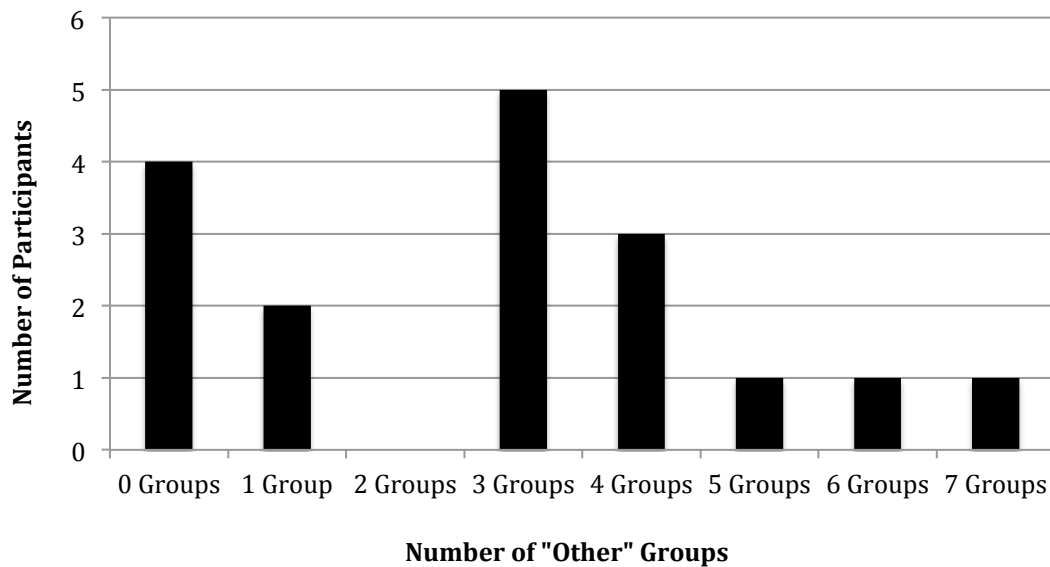
Information Source	<i>N=17</i>
Formal Sources of Information	
Doctors or nurses	16
Pamphlets	16
Safer drug kits	15
Street Connections van	15
Counsellor/ support workers	14
Outreach workers	14
Drug treatment centres	10
Distribution site	9
School teachers	2
Other (1 unspecified, 1 jail)	2
Informal Sources of Information	
Friends	15
Acquaintances	14
Peer groups	14
Partners	11
Party friends	10
Family member	7
Co-workers	6
Dealers	3
Schoolmates	3
Other (unspecified)	2

All 17 participants identified at least one formal and informal source of information; implying they use both formal and informal sources to obtain information. Doctors or nurses (n=16), pamphlets (n=16), safer drug kits (n=15), Street Connections van (n=15), counselor/ support workers (n=4), outreach workers (n=14), drug treatment centres (n=10), and distribution sites (n=9) were formal sources where the majority of participants accessed information. Friends (n=15), acquaintances (n=14), peer groups (n=14), partners (n=11), and party friends (n=10) were informal sources identified by the majority of participants. Additional informal sources of information were family (n=7),

co-workers (n=6), dealers (n=3), and schoolmates (n=3), which were reported by only a few participants.

On the structured questionnaire, participants were asked, “*Are you involved in any other groups listed below? If Yes, please list all groups below.*” The purpose of asking this question was to explore the different venues that participants are involved in where they may receive information and possibly share information. It is important to note that the question explored groups participants were involved in but did not ask about employment or other programming, which is valuable information when exploring sources of information.

Figure 3.3 Number of groups, outside The 595, participants report engagement in



In addition to all 17 participants engaging with the 595PWG, 13 stated they are in at least one other group. Only four reported the 595PWG as their only engagement.

Participants did not specify if these are groups they are currently or were previously engaged in. Some participants are involved in numerous groups concurrently.

Table 3.6 *Groups that Participants Reported Engagement In*

Name of Group	<i>N=17</i>
Mount Carmel Clinic, Sage House Anti-Violence Advisory Team-4 Mothering Project-1	5
Canadian Aboriginal AIDS Network	4
Nine Circles Community Health Centre	4
People Living with HIV/AIDS (PHA) Caucus	4
Sunshine House/ Kali Shiva	3
Canadian AIDS Treatment Information Exchange (CATIE)	2
Ka Ni Kanichihk Inc. Aboriginal Women Responding to the AIDS Crisis Program -1	2
Klinik, Dreamcatchers Program	2
New Directions, Transition, Education & Resource for Females	2
Sex Workers Addressing Treatment (SWAT)	2
Two-Spirited People of Manitoba Inc.	2
Canadian Area Network of Drug Users	1
Grandmother Moon Lodge	1
Manitoba Area Network of Drug Users (MANDU)	1
Manitoba First Nations AIDS Working Group (MFNAWG)	1
Sexually Exploited Youth Community Coalition	1

These groups range from organizations that the participants access in which harm reduction services are available (e.g. Sage House) to groups in which they actively do harm reduction work (e.g. Anti-Violence Advisory Team). While only three people identified Sage House as a group they are engaged in, in the transcripts, many more participants specifically cited accessing Sage House in order to access resources and harm reduction supplies. This sheds some insight into the difference between “being engaged” with an organization, and simply accessing an organization. There was a similar case for Nine Circles; the majority of participants stated they access supplies and

resources at Nine Circles but only four participants stated they are involved with this organization. Additionally, one participant included her place of employment as well as a treatment program she is currently involved in. Again, the study would have benefited from the inclusion of employment and programming options in the questionnaire.

3.7 Data Analysis

The analytical approach of the study was content and thematic analysis (Patton, 2002). Content analysis “is used to refer to any qualitative data reduction and sense-making effort that takes a volume of qualitative material and attempts to identify core consistencies and meanings” (p.453). The following steps were taken in order to complete the data analysis.

The first step was analyzing transcripts and interview notes for content pertaining to each interview question. For example, for the question, “*What do you consider key information on drug use that people should know?*” relevant quotes from each transcript were extracted and pasted into an Excel document under this research question. *Figure 3.4*, shows how Joe’s statement was pasted in the excel document under the topic of “*do not use today*”

Figure 3.4 Example of Excel document following step 1

	Do not use today
Joe	say if they’re on the fence about it... sometimes it can be just as easy to talk somebody down from it... I think it is easier to walk away from doing it at times...

The second step in the data analysis was grouping topics together based on each interview question. Using flip chart paper and a printout of the Excel document the researcher and the research coordinator categorized topics into themes for each question. The researcher then made adjustments to the Excel document to reflect the themes. *Figure 3.5* shows the topics (do not use, do not use today, do not use a specific drug, and use a harm reduction formula) categorized under a theme (Do not use/ harm reduction).

Figure 3.5 Example of Excel document following step 2

	Do Not Use/ Harm Reduction			
	Do not use	Do not use today	Do not use a specific drug	Use a harm reduction formula
Joe	yes	say if they're on the fence about it...		
Charlie				well I'd rather drink 2 or 3 beer a day...

The third step in data analysis was verifying the updated Excel document. Independently, the research coordinator compared the Excel document with each of the interviews to ensure that all of the information in the transcripts/interview notes was accurately captured in the Excel document. The fourth step in data analysis was presenting the themes and topics to the CIHR research team (members of the academic committee, and two peer researchers). Themes and topics were discussed, verified, and justified. The fifth step of analysis involved presenting the themes to the study participants at a CBR meeting. Themes and topics were verified and further analysis was provided through member checking (discussed in section 3.8).

3.8 Community Based Research Meetings

Starting in January 2013, a monthly CBR meeting was held with all of the participants. This continued until December 2013 when the CIHR funded project ended. Meetings were attended by the 595PWG, the researcher, and the research coordinator. The purpose of the meetings were to discuss the research, build research capacity, and conduct member checking of the data. Member checking is the process of sharing emerging interpretations with the participants so that they can verify if the data and the analysis are correct (McMillan, 2008, p.297).

3.8.1 Getting consent for the research coordinator to view transcripts

The consent form signed by the participants allowed for the researcher to view the transcripts but did not allow for the research coordinator. When the analysis began, it was evident that the process would benefit by having the research coordinator review the transcripts. In February, a meeting was held and consent was requested. The rationale of assistance with data analysis was provided and an explanation was offered of the terms of confidentiality that would surround access to these transcripts. Participants were asked to sign a document indicating consent for the research coordinator to access their transcripts; all 17 participants agreed.

3.8.2 Data analysis activities

One of the project objectives was building on peer capacity. To do this, a number of activities were facilitated during the CBR meetings. To illustrate data analysis, the research coordinator developed the “Grocery List Activity” (Appendix H). The group

was presented with a grocery list of approximately 12 items and was asked to “sort it.” This began with a discussion about all of the different ways the list could be grouped together and “analyzed” (by food group, by frozen foods versus fresh foods, by aisle numbers in a grocery store, etc). Once the group decided to sort by food group, there were some items that were straight forward to categorize, such as celery (fruits and vegetables), and some items that required further discussion, such as pizza (did it belong in fruit and vegetable, breads and grains, meat, or “other”?). An explanation was offered about how sorting this grocery list is similar to data analysis: both activities are looking to organize the information by grouping like ideas together. Following the grocery list activity, the group was divided into smaller groups of approximately three or four people and given an excerpt (2 to 3 pages) from an interview transcript (identifying information was excluded). The small groups then worked to review the excerpt for information that answered the question “*What do you consider key information on drug use that people should know?*” The groups recorded their information on a flip chart and presented back to the larger group. The participants provided feedback of the activity with the majority stating that they enjoyed the learning experience. They also expressed that they would not be interested in conducting qualitative data analysis themselves.

3.8.3 Data interpretation activity

When the second questionnaire was administered, a few of the participants wrote comments such as “way older than you” and “why do you want to know?” when asked to identify their age. In response to these comments and to help explain why demographic information, such as age, is helpful in research, the research coordinator developed a data

analysis activity titled, “*How well do you know your Peers?*”(Appendix I). The activity included five multiple-choice questions about the group. *Figure 3.6* shows an example of one question.

Figure 3.6 Question 3 on “*How well do you know your Peers?*” questionnaire

3. Of the 17 Peers who did the first survey, how many people do you think are currently renting (the place they stay)?	
a. 5 of the 17 peers are renting	b. 12 of the 17 peers are renting
c. 9 of the 17 peers are renting	d. 16 of the 17 peers are renting

The purpose of the activity was twofold. The first was to demonstrate that you cannot make inferences about a population just by observation or assumption. Even if you are a member of that group it is hard to know everything about it. Of the 16 participants that answered the questions in this activity, no one had all five questions correct, only one had four questions correct, and most had two or three questions correct. The participants’ feedback indicated that they were surprised that even they did not know themselves and they had all been in the group for two or more years.

The second purpose of this activity was to demonstrate the different ways that data can be represented. For example, with the exercise, how the different multiple choice options provided either made the actual answer seem on the low side, on the high side, or right in the middle. We also discussed how averages could be misleading, and that alternate options (such as sharing the range of responses) can be helpful. The group

voiced that they liked the idea of including both an average and the range of data in the analysis.

3.8.4 Glossary development

One aspect that became apparent during both the interview and transcribing process centered on the issue of language. There were a variety of terms that are commonly used, but not often specifically defined such as mental health, addiction, and exploitation. The 595PWG was consulted in order to better understand what these terms meant to them for the glossary. One particular term that warranted conversation was the term “mental health.” As noted previously, the participants specified mental health as a health condition they wanted included on the structured questionnaire. During subsequent member checking, the group was asked what they understood “mental health” to encompass. The term was discussed and participants identified what it meant to them. Other terms that were discussed for the glossary included clean, dirty, chipping, double up, and cuff. These terms are included in the glossary. Unpacking the use of these terms provides valuable insight into the “real life” circumstances of the participants.

Chapter 4 - Findings and Results

In this chapter you will see the results of the participants responses to the following questions: do you share safer drug use and safer sex information, who do you share information with, do you adapt information based on who you are sharing with and why do you share information? Participants also identified what they thought were key messages related to safer drug use and safer sex. Some participants elaborated on what conditions may create barriers to sharing key messages as well as key messages that they do not share. Throughout the interviews, participants highlighted challenges related to sharing information. The more prominent challenges will be shared at the end of this chapter.

4.1 Sharing Safer Drug use and Safer Sex Information

When asked if they share safer drug use and safer sex information with anyone, 16 of the 17 participants indicated “yes”, they do share information. While Lisa (Female, age unspecified) indicated that she does not actively share information, she did state, “I probably talked about it with other people. The solvents. Just say... how it makes you feel and what it does to you and what kind of high do you get.” Lisa’s quote suggests that while she does not necessarily share safer drug use information, she does discuss other types of drug-related information.

4.1.1 Who do you share Safer Drug Use and Safer Sex information with?

Table 4.1 *Participants Recall of Whom They Share Information With*

	Safer Drug Use N=17	Safer Sex N=17
Family Members	13	15
Children/ grandchildren	7	8
Nieces / nephews	5	6
Siblings	4	3
Parents	3	5
Grandparents	1	1
Partner/ Spouse	3	4
Friends	15	10
General Public	13	13
Anybody	12	12
Youth	7	6
Seniors	4	3
Sex Trade Workers	3	8
Sex Work clients	3	4
Dealers	3	1
My doctor / other professionals	2	2

Thirteen participants indicated they shared safer drug use information with family members while 15 shared safer sex information with them. Broken down, “family members” includes their children and/or grandchildren (safer drug use n=7, safer sex n=8), nieces and nephews (safer drug use n=5, safer sex n=6), siblings (safer drug use n=4, safer sex n=3), parents (safer drug use n=3, safer sex=5), and grandparents (safer drug use n=1, safer sex n=1). Two participants stated that they do not talk to their family about safer drug use; Sara (Transgender, 33) indicated that she has tried to share with them but they do not want to engage in that conversation; “they refuse to talk about that.” Another participant stated he talks to other family members but does not share information with his mom. A number of participants stated that sometimes it is a challenge to talk to their family about safer sex. Monica (Female, age unspecified) stated, “I talk to my family members but it’s just kind of shut down right away.”

Interestingly, only three participants indicated that they share safer drug use information and four share safer sex information with their partner or spouse. This is particularly surprising in light of the substantial quantity of participants who indicated their partner was a source of information (n=11). It appears that for some participants, information exchange is mutual; Frank (Male, 42) stated, “My partner, he’s the one that actually informs me and we go back and forth sharing information.” Some participants had clear reasons as to why they do not share with their partners. Julie (Transgender, age unspecified) indicated that both her method of drug use and drug of choice were incongruent with her partner’s which may have created a barrier to sharing information; “He wasn’t into too much of doing needles, he was more of a pot head I guess you could say. He did hash. I don’t like that type of thing.”

Many participants identified friends as a group that they shared safer drug use (n=15) and safer sex (n=10) information with. A “friend” included close friends, acquaintances, and party friends. A variety of reasons were given as to why some participants do not share safer drug use with friends; this included incongruent drug use experiences, others not using drugs at all, or feeling like others already knew *everything*. As Julie (Transgender, age unspecified) stated, “They pretty much knew already, I didn’t need to tell them anything. They were the ones telling me everything.” Additionally, some participants identified difficulties in sharing safer sex information with friends; most noteworthy was an incongruent sexual orientation. John (Male, 50) stated, “I won’t talk to [name’s] friends because they’re straight. I’m gay and me talking to a straight guy about gay sex or sex period, they just don’t want to hear it.”

Sharing information with the general public was identified by 13 of the participants. This included sharing information with “anybody” (safer drug use/ safer sex n=12), or particular age groups such as youth (safer drug use n=7, safer sex n=6), and seniors (safer drug use n=4, safer sex n=3). Some participants talked about some of the challenges involved in talking with youth. In particular, Erin (Pangender, 40) noted that parents often interfere or discourage the sharing of information; “They’re like ‘you shouldn’t be saying that to my kid.’ I will just take them away from there to talk.”

Some participants stated they share information with sex workers (safer drug use n=3, safer sex n=8). Six identified as sex workers themselves. Although the other two were not involved in sex work, one of those participants used to be a dealer for women involved in sex work and the other does outreach in his community (provides safer drug use and safer sex information and supplies to members of his community). Further, some individuals involved in sex work indicated that they share information with their sex work clients (safer drug use n=3, safer sex n=4).

The concept of sharing with drug dealers was a topic that created an interesting distinction between the participants. Two respondents indicated that they do not have drug dealers because they use prescription drugs (instead relying on their doctors to obtain their drugs). Eight participants stated they do not talk to their dealers at all about safer drug use or safer sex information. As Heather (Female, 51) summed up; “It’s just all about business.” Likewise, John (Male, 50) had this to say; “My crack dealer, I’ve had a relationship for, going on ten years, he just asks me how I’m doing but that’s it. They want you to use them, want to get your money. They’re not going to tell you ‘well here’s a little better and here’s a little more. To keep you clean. To keep you safe.’”

Of those who discussed dealers, three indicated they share safer drug use information and one indicated she shared safer sex information with their dealer. All of these participants identified involvement in sex work, which implies a relationship with their drug dealers that allows for the sharing of information. During member checking the participants shared some valuable information regarding this relationship. It was stated that individual that are involved in sex work often have a more personal or intimate relationship with their dealers. They noted that dealers would sometimes *cuff you* (front you the drugs and you pay later) or give you *trades* (exchange drugs for sexual activity). One woman involved in sex work stated that when you are working you want to know “everyone” and that includes your dealers. She indicated that sex workers may spend more time with their dealer than those not involved in sex work; this was supported by a participant who identified as a former drug dealer. He elaborated stating dealers will call sex workers and ask if they need “anything” (drugs) and explained that sex workers were his regular clients (those who purchased drugs from him). He stated, “Those girls (sex workers) are going to keep you safe out there. They will keep you informed so you are going to try to keep them happy because they also keep you safe.” While there is a body of research describing that there is “a clear interdependence between sex work and drugs” (Morozini, 2011), this relationship is often limited to exploring supply and demand, and “what came first?” types of questions. The mutually *protective* relationship between drug dealers and sex workers is an area in which there is much room to explore.

Two of the participants stated they share safer drug use and safer sex information with their doctors or other professionals. One participant noted that her doctor is very informed as she deals with a lot of “street people” and works with “that population”. She

stated she talks all the time about it with her doctor. However, Kim (Female, age unspecified) had a contrary view stating, “I won’t talk to doctors or nurses or lawyers or anything like that because I figure they know or they don’t.”

4.1.2 Where do you share safer drug use and safer sex information?

Table 4.2 *Where Do You Share Information?*

Location	N=17
At parties	12
During drug use	10
Anywhere	10
At other organizations	10
At home	10
At conferences	4

When exploring where they share information, participants identified locations where they spend time every day. This supports the notion that sharing of information happens on a daily basis in a natural and organic way. Twelve participants stated that they share information at parties; two specifically stated “at crack shacks.” Ten participants stated they actively share information in their homes, while one of these individuals stated she only shares safer sex information at home. During drug use (n=10) was another time that information was shared, which can happen at parties or at participants’ homes. There were specific considerations that participants highlighted when sharing during drug use, as John stated:

“That would be the best time, but it’s not really the best time because people are there to get high, to forget their wills, forget their deals and they don’t want to have to listen to me. ‘Well you should really do this cause this is safer’.... ‘Fuck you I just want to get high.’ But it’s usually while they are high because they will start

talking about “Oh I know this guy that’s got HIV and I smoked behind him’ and that’s when everybody starts freaking out because they’re already high.”

John, Male, 50

There appear to be social guidelines as to how individuals share safer drug use information at parties; including whose house it is, if the individual who is sharing information is using or just observing, and what kind of drugs are being used (same or different from one another). Sharing information in these circumstances might be interpreted as overstepping some boundaries and may not be as well-received.

Ten of the participants stated they share information “anywhere”. This included public places such as McDonalds, on the street, on the bus, at the soup kitchen, while doing outreach, and at pow wows. Some of the participants involved in sex work noted that they share information on “track” (the streets where sex work is conducted). Additionally, ten participants stated they share information at other organizations with either service providers or program participants. Other organizations identified were Manitoba First Nations AIDS Working Group (MFNAWG), Sage House, Transition, Education and Resources for Females (TERF), West Broadway Community Centre, community drop in programs, and at their place of employment. Four participants identified sharing information at conferences and one stated he shared information while he was in jail.

4.1.3 How do you share safer drug use and safer sex information?

According to participants, the majority of sharing happens when the topic of drugs or sex “comes up” during a conversation (n=16). This further supports the notion

that sharing information is organic. As Monica (Female, age unspecified) stated, “I sit around on the bed in her [granddaughter’s] bedroom and I talk to the girls about safe sex.” When describing how distribution is added to the conversation, Erin (Pangender, 40) had this to say, “We were sitting outside and people were talking about condoms so I go back outside and say well here’s a box.” While many of the participants expressed a personal commitment and interest in sharing safer drug use and safer sex information, some also noted that sometimes one has to choose not to engage in the conversation. This seems to be particularly important to be able to navigate when one overhears incorrect information. As Joe (Male, 51) stated, “There are times that you just choose not to respond; sometimes I’m not even going to go there.” Further, John (Male, 50) stated, “I just get a sixth sense of who I can share with and who I can’t. So you have to kind of figure out if it would be a waste of time or a good thing.”

Eight participants stated they deliver safer drug use and safer sex messages via peer delivered workshops (workshops facilitated by a peer) while five participants also highlighted the use of technology (n=5) to deliver messages. This included the phone, texting, and Facebook. The idea of using technology and advancements in social media to communicate safer drug use and safer sex will be discussed in section 5.5 *Future Research*.

4.1.4 Adapting safer drug use and safer sex information

Participants were asked if they adapted messages when sharing information, and under what context the adaptations took place. In reviewing the transcripts, it appeared that there were two schools of thought about this issue. The first group felt that it was

best to give the information “straight” to everyone and to not adapt messaging or “water it down”, regardless of the age of the participant. The second group indicated that they did adapt information. For some groups (notably children and youth) they might incorporate less explicit topics, or may modify the language used to describe the topic (particularly around safer sex information). However, despite the two approaches, the thread that ties both groups together is that they are both trying to provide information in the best interest of *who* they are talking to.

4.1.5 Why do participants share Safer Drug Use and Safer Sex information?

During the interview, some participants were asked why they share information; what motivated you to share and why do you feel is it important to keep sharing information? Overwhelmingly participants stated they share information because they want to help each other out, as John (Male, 50) sums up, “If I know something, and that could be anything that you don’t know, I will tell you. It doesn’t matter if it has to do with sex, drugs, playing a guitar. I will try to show you a better way, a safer way.” Additionally, one participant stated he is trying to stop others from making the same mistake he did, “If I see somebody dropping a needle, like you know the same mistake I did, I tell them ‘don’t use it it’s not yours.’ I wish I had somebody like me now to say don’t do that... I didn’t want anyone to have what I have” (Name omitted).

Furthermore, participants that are HIV or hepatitis C positive stated they share information in hopes of preventing those they care about from acquiring HIV/ hepatitis C and having to go through what they did. One participant even stated he would not wish this (HIV) on his worst enemy. Another participant stated that since being diagnosed with

HIV he shares more now than he ever did. The process of sharing information following a positive diagnosis is quite a challenge as noted by one participant:

“I had a dormant time there when I didn’t [share] for about 8 months... Where I was traumatized. I didn’t want to see anybody... You know for the first couple years after I was angry. I couldn’t do the professional work that I used to do. My money has been reduced dramatically... I had this horrible thing that destroyed my life and destroyed my career and I did not want to see anybody else that I loved and cared about to have that... You know I wouldn’t wish this upon anybody after what it did to me... like you know I had my whole life ahead of me and it was going really good.”

(Name omitted)

In addition to wanting to prevent other people from getting HIV, another participant talked about wanting to give back to the organization and people that helped him. His priority in sharing information is not only prevention but also helping others who have HIV to live a healthy life.

4.2 Key Messages for Safer Drug Use

Participants were asked, “*What do you consider to be key information on drug use that people should know?*” There were six themes of information about drug use that the participants identified. Each of the six themes had various sub-topics included within it.

4.2.1 Know your drug(s)

Table 4.3 *Key Messages of Safer Drug use Theme 1: Know Your Drug(s)*

	<i>N</i> = 17
Know your drugs	17
Know what the drug(s) can do to you	14
Know your limits (overdose prevention)	11
Know how to use your drug(s) properly	10
Know how to use your drug(s) with other drugs	6
Know the relationship between drug use and sex	9

4.2.1.1 *Know what the drug(s) can do to you*

All 17 of the participants identified knowing your drug as an important message in safer drug use. Fourteen of these individuals said that it is important to know what drugs can do to you. This included the effects that the drugs have on your body, as Julie (Transgender, age unspecified) stated, “I think that’s what really made me quit, because I just got so depressed, thinking suicide and all that. I figured no more drugs for me if I’m going to be thinking like that.” When looking at the impact of drugs, many of the participants talked about the impact that their use has had on them personally or on other people. Charlie (Male, 62) described being high and out of control stating, “With crack, there was nothing. You just used it, no food, no nourishment.” When talking about using solvents, Lisa had this to say:

“I used to sniff [solvents] all the time around here... lacquer thinner, gasoline...you get headaches, you get really bad ones and sick, puke, watery stuff and everything. And watery eyes and depression... and suicidal too... I sometimes looked at myself in the mirror and I was skinny, my face was just saggy...It's like a witch looking at you. Your face is skinny, your arms are skinny, you don't look so good, your eyes

have bags underneath and black like dark circles under your eyes and tired...just like you're a zombie, a walking zombie. Like a dead person.”

Lisa (Female, age unspecified)

Joel went on to describe the impact that using drugs was having on his body’s ability to “fight” his hepatitis C and what a friend told him:

“Even my ex biker friend said ‘Hey Joel, I know you got hep C but why don’t you just stop doing the morphine cause every time you shoot that morphine all your antibodies go from your hep C to that. They abandon that battle to go fight this new thing in your system. You’re splitting up your armies. It’s like Hitler. He went too far man. He had his whole army all over the world and he couldn’t, he ran out of supplies and he got knocked over. That’s like your body. You keep doing these different dopes and your system automatically goes to anything that enters your body that’s foreign for a battle ‘cause that’s what it’s designed to do.’ So I learned that from him. He wasn’t even a drug addict.”

Joel (Male, 51)

4.2.1.2 Know your limits

Fourteen participants talked about knowing your limits when using drugs. Many of those talked about limits in relation to overdosing; the value of knowing your tolerance so you can prevent overdose. Many participants had experienced overdosing on drugs. John (Male, 50) tells others to, “Use a little bit at a time before you start because if you don’t know what it is you may might end up in the hospital.” One participant talked about limits in relation to the amount you are using and how often you use. This combination is

referring to binge using and the impact that using too often will have on you. Sometimes this had to do with knowing your limits when you are out of control and how to maintain control; Frank (Male, 42) stated, “Once you get that tingly feeling like when you’re drinking or something, you know the next one’s going to set you off. Well it’s time to stop right there. Always be in control. Always know your surroundings.”

4.2.1.3 Know how to use your drug(s) properly

Ten participants talked about knowing how to use your drug properly, whether you are injecting or smoking drugs. When it comes to injecting this included knowing where to inject and how to inject as safely as possible. In exploring how participants that disclosed injection drug use learned to do their drugs *properly*, all noted they had some guidance from others that injected.

“I had somebody do it for me and I just watched them... [I started injecting myself] maybe six months later... I probably asked a question or two then. A couple other friends gave me some tips here and there but as far as mixing, how much to mix and stuff like that, I never really got into those topics with anybody. But I think I had some people looking out for me... trying to tell me be careful how much you’re doing... stuff like that.”

Joe (Male, 41)

Erin (Pangender, 40) talked about his struggle to learn how to inject properly and that even after a year and a half decided to stop injecting because he could not do it; “I injected... I only did it for about a year cause I couldn’t find my veins... no I wasn’t very

good at it... I just hated the bruises. The way it looked. I tried it all over, my legs, my arms and I had bruises so I just said screw that. It's not for me."

For those that did inject drugs, the research asked if they ever injected others or showed others how to inject themselves properly. Those that answered provided valuable insight into this dynamic. Joe (Male, 41) stated, "People have asked me to hit them but I don't want that responsibility of missing or even poking people... I'm not big on promoting drugs." Anna (Female, age unspecified) shared that she had injected other people and sometimes she did this under conditions that were not ideal; "I remember like the first time I ever shot up with this girl, it was her first time. We were in some grungy bathroom and I just went to shoot her up in the bathroom."

Kim (Female, age unspecified) talked about the benefits of not teaching others how to do it themselves. She stated that part of "hitting" others was that they would provide you with some of the drugs and therefore you did not have to go get them yourself; "I could just sit there and not have to go out and work and people would come in and I would get hooked up just for fixing them." On the other hand, Anna (Female, age unspecified) stated that it was the cost of having to pay someone to shoot her up that motivated her to learn how to do it herself; "I got sick of paying people to shoot me up. So I bought a whole bunch of valiums and I taught myself how to shoot up."

4.2.1.4 Know how to use your drug(s) with other drugs

When talking about knowing how to use your drugs in combination with other drugs (n=6), many of the statements had to do with mixing drugs with alcohol. John (Male, 50) stated, "Alcohol is really not a good thing to mix with other drugs because the

alcohol will mix and that's when you really get stupid and lose it. It's either one or the other." Further, Elliot (Male, 42) talked about how mixing drugs and alcohol can impact taking your medication, in this case HIV medications; "Using drugs and alcohol, they forget to take their HIV meds."

4.2.1.5 Know the relationship between drug use and sex

Nine of the participants identified a connection between drugs and sex. The participants acknowledged that there is an increased potential of sexual behavior when using drugs, and that it is possible to end up having sex with people you are using drugs with; "Some people using meth and crack, they'll do group sex. Get to know who you're smoking with before you have sex" (John, Male, 50). In addition, seven of the nine talked about sex work and exploitation and the connection with drug use. Jane (Transgender, age unspecified) cautioned others to always carry a condom, "When using, you are vulnerable to exploit yourself." Sara (Transgender, 33) elaborated further on the risk of exploitation stating, "Well they don't even know they're doing the activity, or the person is perhaps should I say 'raping' without consent if the person is passed out... that's the most dangerous activities that happens at some parties."

4.2.2 Drug use equipment

Table 4.4 *Key Messages of Safer Drug Use Theme 2: Drug Use Equipment*

	<i>N</i> = 17
Drug Use Equipment	16
Have your own equipment	15
Know where to get your equipment	15
Do not share your equipment	14
Know how to use your equipment properly	11

4.2.2.1 *Have your own equipment and know where to get it*

Sixteen of the participants talked about equipment and of those individuals, fifteen identified that it is important to have your own equipment and know where to get it. Participants listed places where they could obtain new equipment including Nine Circles, Sage House, The 595 Prevention Team Inc., and Street Connections (Winnipeg Regional Health Authority). It is important to note that nine of the participants discussed that there is currently limited access to safer drug use equipment. During subsequent member checking, participants indicated that access is always changing; organizations are shutting down, changing hours of distribution, or changing limitations on equipment. Further, it was noted that often the hours of distribution do not align with when individuals are using. Frank (Male, 42) stated, “You know, people either want their supplies [equipment] first thing in the morning when they pick up their medication or they want it late at night when things are closed.” Some participants stated that they are comfortable accessing services and equipment at various organizations and satisfied with the services they receive. However, for others, the stigma of drug use and/or their health status can create a barrier to accessing services. Joel highlighted both sides of the argument in his statement;

“When you’re out in the free world this shit’s free, there’s no reason why you should have to share anything with anybody ‘cause it’s there for the taking. You just got to get off your ass and go get it.... Or get somebody to go get it for you. So this is where I found out where I had to go and actually help people because I realized that some people were too shy or too afraid. They didn’t want to be seen ;cause these places would stand out. Same with when you come to Nine Circles. Everybody thinks that whoever comes through that door is AIDS.”

Joel (Male, 51)

Some participants talked about the policies of the organization being a barrier to accessing safer drug use equipment. As Jane (Transgender, age unspecified) stated, “[organization] only allows one [crack pipe]. That’s so stupid ‘cause we would pick up for each other if they let us.” All seventeen participants stated they do some distribution of safer drug use and/or safer sex equipment. Participants specified what types of materials they distribute, this included items such as pipes, injection drug use equipment, condoms, pamphlets, and newsletters. As was evident in the data, participants consistently pick up extra equipment (even equipment they do not use) for their friends and family. Erin (Pangender, 40) stated, “I get [condoms] free from my doctor ‘cause I get a prescription. I get like 48 condoms at a time. Every time, even if I don’t need them I order them. I give them to my nephews, everybody, whoever’s around.” Joel (Male, 51) shared how he did distribution with others that injected drugs; “If you’re a heavy user they’ll give you a box [of needles]. That’s what they did to me. I had people always stopping over to get rigs [needles] and I’d just give them a handful.” Sara (Transgender, 33) elaborated on supply distribution stating that some of her friends have their reasons

for not going to get their own supplies and would rather pay to get her high if she will get supplies for them; “I even would go get it for them ‘cause some of them are just way to embarrassed and it’s like ‘I’ll scratch yours and you’ll scratch mine. Go get me these and I’ll get you high.’”

However, carrying extra supplies for distribution is not without its challenges. For example, Joel reported getting hassled by the police while doing distribution; “[The police] thought I was a drug dealer because I had two phones strapped to my hip and walking around with a bag full of kits [injection drug use equipment]. The cops had come to street connections. And after that I wasn’t able to grab a bag [of kits].” Joel indicated that this resulted in not be able to access large quantities of supplies to do distribution in his community.

Two of the participants noted that in addition to doing distribution, they also did needle disposal which included collecting used needles in a biohazard box and organizing delivery to the regional health authority for proper disposal; “We drop off now quite a bit [of needles] to WRHA ourselves” (Monica, Female, age unspecified). Joel (Male, 51) also talked about providing small biohazard boxes for individuals to dispose of their own needles safely.

It is noteworthy that patterns of distribution change for some people if they stop using drugs. Charlie (Male, 62) stated that once he quit using crack, he no longer carried pipes to distribute. Another individual shared that because she does not allow crack use in her home she no longer does distribution of crack pipes; however she continues to tell people where they can access crack pipes.

4.2.2.2 *Do not share your equipment*

Another topic addressed under the theme of equipment was of the importance of not sharing your drug equipment (n=14). Some participants who did not identify this message did not report injecting drugs; for example, Charlie who smoked crack or Lisa who used solvents did not. Participants identified that this message is more prominent in drug using networks than it ever has been; “I’m thinking more and more people now a days aren’t into sharing equipment compared to when I first started using in the 70’s. A lot of things have changed when it comes to drug users now” (Monica, Female, age unspecified). To elaborate, Kim (Female, age unspecified) used the word *obviously* to emphasize that it is common knowledge now amongst injection drug users; “Obviously don’t share any drug paraphernalia whatsoever, not even water.”

During member checking, individuals shared that they are creative about how to prevent sharing their own equipment. Strategies included telling others that they do not want them to “push” their resin in their crack pipe (push the resin down the pipe and smoke it), that they do not want to share germs, or that they do not know the other person’s health status. These strategies were particularly important for those individuals that did not want to disclose their HIV or hepatitis C status as the rationale for not sharing equipment. Although in the minority, a few participants indicated that they are open about disclosing their positive health status. While there are different motivations for this, one participant, who was co-infected with HIV and hepatitis C, tells others he is still hepatitis C positive (even though he was cured) so he does not have to disclose his HIV status. Another participant talked about the benefit of disclosing so that no one will “want

your stuff.” Furthermore, another participant stated he shares HIV status and marks his equipment with a black marker so everyone knows what equipment is his.

4.2.2.3 Know how to use your equipment properly

Knowing how to use your equipment properly was identified by 11 of the participants. Participants talked about the risk of using brillo in crack pipes. Brillo is steel wool that is placed in the end of a crack pipe to hold the crack in place while smoking. Pieces of the steel wool break off and can cause an infection in your throat or lungs. Participants also discussed vein care, the safest places to inject drugs, and storing your equipment safely. Others talked about preventing drug-related infections such as abscesses, cysts, and cotton fever. As Frank (Male, 42) stated, “You’re handling a lot of stuff. The bacteria you picked up during the day... Always make sure your hands are clean before you’re scraping your pills. Make sure you wash your hands before you do any drug use... Especially if you’re shooting up [injecting].”

4.2.3 STBBI and other infections

Table 4.5 *Key Messages of Safer Drug Use Theme 3: STBBI and Other Infections*

	<i>N=17</i>
STBBI and Other Infections	16
HIV and hepatitis C transmission	16
Other infections	9
Testing	8
STI transmission	5

4.2.3.1 HIV and hepatitis C transmission

Sixteen of the participants identified STBBI and other infections as an important topic to share information about. Sixteen of the participants talked specifically about HIV and hepatitis C transmission. Of the 12 participants that reported being either HIV positive, hepatitis C positive, or co-infected with HIV and hepatitis C, many were able to identify when they believe they contracted HIV/ hepatitis C. It is common that service providers ask clients “What would have stopped you from using that needle and prevented transmission?” Based on the interview data, it seems that for some people, there is nothing that could have stopped them from sharing a needle other than a new needle being available. As one participant stated, “Any needle user will tell you this, when you got your shit and there’s no clean needle around you will grab any needle because that’s how bad you want it... This one girl she was hep c and she told me straight up ‘No [name] I got hep c.’ I don’t fucking care and I used it anyways” (Name omitted). Likewise, another participant stated, “When you’re drug addicted you’re going through withdrawal to be drug sick, you’re taking a chance to catch HIV just to become not drug sick. Being drug sick on opiates, it’s such a terrible terrible thing to go through... I shared a fair amount of times” (Name omitted).

It was clear that the participants have a wealth of knowledge about many STBBI, however, six participants stated incorrect information about HIV or hepatitis C. Of these six participants, three are positive (or have been positive for HIV and hepatitis C, 2 are cured of hepatitis C). Misinformation included routes of transmission as one participant demonstrated when discussing how he acquired HIV: “I never went the ‘other way’... the

only other people I've been with are women.” This comment reflects outdated information, in which HIV was believed to be a “gay man’s” infection.

Eight of the participants talked about how the general public is misinformed about transmission risks related HIV or hepatitis C. Some of the comments they shared included; “HIV is still a gay disease to some people,” “There is no reason for you to Javex your dishes when I’m leaving [because I have HIV],” and “They still think you can get it from drinking from a cup... from just kissing somebody.” Another participant shared that this misinformation could be found even within medical supports. She (name omitted) described that due to her HIV status, she is not allowed to use the medical van from her community: “I got three appointments the whole day, but I’m not allowed to go in the medical van because kids are there and elders are there.”

4.2.3.2 Sexually transmitted infections (STI) and other infections

In addition to HIV and hepatitis C, participants stated that others should be aware of STI such as gonorrhea and chlamydia (n=5). Nine participants also mentioned the transmission of other infections such as tuberculosis, the flu, and cold sores.

4.2.3.3 Testing

The topic of testing elicited a variety of interesting responses from the participants. Eight participants stated they share testing information with others; one participant specified that she only shares testing information with her daughter. Sara (Transgender, 33) stated that not only does she encourage testing, she also talks to others about retesting, “I always motivate retesting all the time.” Several participants noted barriers to

sharing testing information included the sensitive nature of the topic, fear of having to disclose your own status, and fear of receiving a negative response from others. Three participants stated they will not tell folks to get tested, two of which reported a negative experience when they tried to tell someone to get tested in the past, “I would never tell them that you should go get tested because some people get really offended by that because you’re stereotyping them... Like why would I? You know it’s always defensive ... I think it would be better done in a group setting than just one-on-one because you’re going to start an argument” (Erin, Pangender, 40). When reflecting on his experience, John (Male, 50) stated, ““What the fuck you talking about man, telling me I got something?’ It’s not even going there... So defensive and there goes the party and there goes everything and no undoing that. You don’t talk about God, and you don’t talk about religion when you’re getting high it just doesn’t mix.”

4.2.4 Do not use

Table 4.6 *Key Messages of Safer Drug Use Theme 4: Do not use*

	<i>N=17</i>
Do not use	15
Do not use or do not use right now	12
Do not use a specific drug	4
Use a harm reduction formula	12

4.2.4.1 *Do not use or do not use right now*

Fifteen of the participants stated that *do not use* is a key message. Twelve of these participants talked specifically about not using drugs and three talked about not using at the moment due to other priorities such as children, bills, or treatment. Joe (Male, 41) stated, “When somebody wants to use but at the same time it’s not in their best interest,

being able to talk to people and say maybe it's just not a good day today... To have them walk away from that or even better yet... they have to make a decision about their child or something... To try to give them something else to look at or to feel better about... Then that's the greatest, that's a good gift." Four of the participants named specific drugs that they told others not to use at all. These drugs included cocaine, ecstasy, fentanyl, crack, and crystal methamphetamine. This was related to the participant having a bad experience with that drug or knowing other people that had a bad experience.

4.2.4.2 Use a harm reduction formula

Twelve of the participants shared harm reduction formulas with others. The 595PWG defines a harm reduction formula as a formula that each Peer uses to reduce the use of more harmful drugs or drug-related activities. It may include using a less harmful drug or, in some cases, a drug of choice; these two things are sometimes the same. Many of the participants identified marijuana as a harm reduction drug (for example, smoking marijuana instead of using a different, potentially more harmful, drug such as crack). One individual identified using alcohol instead of crack. Another participant identified modifying their method of drug use and smoking crack instead of injecting it. When evaluating harms associated with drug use, these are all significant harm reduction strategies. It is important to note that the participants developed their own harm reduction formulas based on their experiences. Louise (Female, age unspecified) stated that she tells others, "If you're trying to quit by doing harm reduction, smoke weed [marijuana] instead of crack. We try to help each other to slow down on the crack use, we try to invite them to smoke a joint or have a beer instead of crack."

4.2.5 How to acquire your drugs

Table 4.7 *Key Messages of Safer Drug Use Theme 5: How to Acquire your Drugs*

	<i>N=17</i>
How to Acquire your drugs	11
Know your drug dealer	10
Know the conditions under which you are purchasing your drugs	6
Maintain your drug supply	6

4.2.5.1 Know your drug dealer

Eleven of the participants stated that drug acquisition was a key message that individuals that were going to do drugs needed to know. Many participants stated that you should know who you are buying your drugs from (n=10). Primarily, this has to do with avoiding getting ripped off. Participants talked about getting your money's worth, getting the drug you actually purchased, and avoiding getting bad drugs (or “dirty” drugs that have been mixed with something else). One way to avoid some of these challenges involved having a regular dealer that you can trust. As Kim (Female, age unspecified) noted, “this is probably going to sound kind of silly but whatever drug a person's using they should always stick to one dealer, so that they know you know kind of what they're getting.”

4.2.5.2 Know the conditions under which you are purchasing your drugs

When reflecting on conditions under which you purchase your drugs, six participants identified the how, what, and where of purchasing your drugs. It was clear that safety when purchasing your drugs was important. “Safety” meant different things to different participants. One participant talked about acquiring your drugs safely without being prosecuted while another talked about gang involvement in the drug trade and

ensuring you are safe when purchasing from a gang member. Others stated that it is important to be aware of the time of day and the location you are buying your drugs to avoid being mugged for your drugs.

4.2.5.3 Maintain your drug supply

Six participants talked about maintaining your drug supply. There were two distinctions made when talking about maintaining your drug supply. Again, the first was having a regular dealer that you trusted, as John (Male, 50) stated, “ The way it usually works it all depends on your income. If you have steady income coming in every two weeks, you’ll have a dealer for life.”

The second was individuals maintaining their prescription drug supply. Participants noted two areas of concern here. The first is maintaining their prescription from a prescribing doctor. Participants stated that rather than a “dealer” they have a doctor that supplies their drugs. It is also notable that some participants have a “legitimate” prescription for pain and choose to inject rather than ingest their dose. Two of the participants stated they inject their drugs because it works faster and is stronger, noting that the digestive system filters the drugs when you ingest it. Frank’s (Male, 42) statement highlights this: “I consider it medicine ‘cause I’m in so much pain. I’m supposed to do it orally but it takes so long for it to kick in and so that’s why I do inject. Don’t ever ask your doctor for anything stronger... They will cut you off right away. You take what you have and never ask for anything stronger.” The second area of concern is protecting their prescriptions from getting stolen. Two participants noted that sometimes they have to be creative to protect their supply from being stolen. Frank (Male, 42) stated,

“I don’t tell anybody what I get because if they found out what I get people would be knocking on my door all the time and calling me and asking me. I don’t go pick up my whole prescription; I just get what I need for that one day so I have to go to the pharmacy every day.” Elliot (Male, 42) also noted, “Don’t carry what you don’t need to. It is becoming more common for gangs to jump people for their prescriptions.”

4.2.6 Know whom you are using drugs with

Table 4.8 *Key Messages of Safer Drug Use Theme 6: Know Who You Are Using Drugs With*

	<i>N = 17</i>
Know whom you are using drugs with	9
Knowing how drugs impact those you are using with	7
Where and with whom you are using	6
Protecting your drugs	5

4.2.6.1 Know how drugs impact those you are using with

Nine participants stated it is important to know who they are using drugs with while seven participants talked specifically about knowing how drugs will impact those they are using with. A number of participants shared that they will not use with “newbies” (individuals that are using drugs for the first time or have recently started using drugs). The participants stated that this was due to concerns about both overdosing as well as the impact the drug will have on the individual’s behaviour, particularly violent behaviours. It was shared that it is important to recognize that everyone reacts differently when under the influence of drugs; “I use by myself and I prefer it that way because there’s no stress of other people, no worries if somebody’s new, I don’t know their behaviour and [you]

kind of get embarrassed too for your behavior” (Sara, Transgender, 33). John (Male, 50) stated it is important to be aware that not everyone reacts to drugs the same way. He elaborated by sharing that on one occasion he tried to help a friend who was feeling depressed, “I remember talking to this guy saying let’s go get high maybe you’ll feel better... So we went and got high and this dude just wanted to kill himself, jump out the window and I’m like dude just sit down. I felt so fucking bad cause I thought it would calm him down but it made him worse.”

4.2.6.2 Where and with whom you are using

Six participants identified the conditions of where you are using and with whom you are using with. Participants noted that it was important to be in a *safe* place to do drugs as well as having someone around just in case something bad happened. Joel (Male, 51) made it clear that he was trying to create a safe place to do drugs that included a phone to call for help in the event that someone did overdose. Joel talked extensively throughout his interview about making sure there are safety nets in place in case something goes wrong during drug use; “Everything was there [at my house]. There’s a phone there ...I’m not going to run out and leave a guy lying on the floor. You’ve got to depend on somebody who has a phone to come to your place.”

Participants shared experiences of being present when others were overdosing and not calling for help due to fear of being prosecuted for using drugs. John (Male, 50) talked about everyone at the party just leaving and not wanting to deal with a friend who was overdosing: “You’re normal then all of a sudden you started going like that and your eyes roll back and then he fell over and everybody freaked out and left.” Even more

compelling was Kim's statement in which she disclosed that when her boyfriend was overdosing, rather than thinking to call for help, she immediately thought about how to dispose of his body.

"We were at my friend's place and we were up in the bathroom, he fixed me, I went and walked away and then I turned around and looked at him and he was [shaking] and then he fell on the ground and he started flopping. Had she [her friend] not been there he probably would have died 'cause I didn't know what the hell. My first thought was, oh my god what are we going to do with his body. And then I called her up but she knew what to do because she was experienced already."

Kim, Female, age unspecified

As an additional consideration, five participants stated they need to know who they are using with in order to protect their supply; other people can steal it or force you to share with them. John (Male, 50) stated, "Your shit gets stolen if you're not paying attention." Frank (Male, 42) talked about his personal experience with this, "It's hard when people are like 'Hey can I have this?' ... I got to get rid of this [drugs] I'm not going to give it to them... If they see it and they want it then they can get violent."

4.3 Key Information for Safer Sex Practices

Participants were asked, "*What do you consider to be key information about sex that people should know?*" Some of the key main messages were discussed with significantly more frequency than others. In particular, the importance of using barriers, such as condoms, was a prevalent message.

Table 4.9 *Key Messages for Safer Sex*

	<i>N</i> = 17
Use a barrier	17
Condoms	17
Other barriers	3
How to use a condom properly	7
HIV, STIs and other infections	11
HIV, STI	11
Other infections (herpes...)	5
Sex work in relation to transmission	7
Testing	4
Know where to get safer sex supplies	10
Know your sex partner	3
Pregnancy	3

4.3.1 Use a barrier

All seventeen participants talked about using a condom or barrier during sex or sexual activity. Two people mentioned dental dams and one mentioned gloves. Many participants identified different types of condoms; Lisa (Female, age unspecified) went on to explain how female (insertive) condoms are more effective as protection, “Female condoms. Those are safe too, they are more safe than the other condoms because they go all around, 'cause sometimes it spreads you know.” When explaining why condom use is so important, Kim (Female, age unspecified) had this to say, “You can’t tell by looking at someone if they have anything. It’s like playing Russian roulette. You only get one chance and one chance only. If you fuck that up you’re screwed.” Some participants had even more specific information on condom use to offer; it is noteworthy that again, these were participants that engage or formerly engaged in sex work.

“A flavored condom is not for penetration at all. It’s only for oral... A stronger condom you want to go to the back door. Then a regular condom you want to go to the front depending on their sexuality and the risk factor of their life style.”

Sara, Transgender, 33

Although he shares information about barriers, Frank (Male, 42) noted that condoms are not always necessary, “Not everyone needs condoms... Not everyone needs to be safe if you know that your partner’s already good right... But then if you don’t trust your partner a hundred percent then you should always use protection.” Furthermore, two of the participants provided a disclaimer that condoms are not always 100 % effective; “Condoms are not always one hundred percent effective... Even with herpes or crabs or anything of that nature. And there is really nothing you can do about it except abstain” (Joe, Male, 41).

Participants also talked about harm reduction and harm reduction formulas in relation to sex. When a condom is not available, you can still engage in sexual activity that does not involve penetration. This might include hand jobs, oral sex and foreplay.

4.3.2 HIV, sexually transmitted infections and other infections

Eleven participants talked about HIV, sexually transmitted infections (STI) and other infections when identifying key messages of safer sex. Specific infections that were discussed included gonorrhea, syphilis, hepatitis, herpes and HIV. Some participants talked about the impact of other infections if you are already HIV or hepatitis C positive; “Herpes is not good to get because it stresses the immune system” (Elliot, Male, 42). Ten

participants stated it is important to know where to get safer sex supplies such as condoms and lube.

Of those participants that identified as being HIV positive, the interviewer asked if they regularly disclose to their sexual partners. All but one said yes.

“It doesn't actually get easier as time goes by...It's always that moment, should I do it or do I bother? ... It's more-so when interest has been shown... It's best to get that out of the way as soon as possible. I mean I really haven't had too many experiences that I felt uncomfortable not divulging ... You know no one has ever said 'you infected fuck.' I have never lost an opportunity... I can't see why somebody would react that way otherwise... That's the whole point to sharing it in the first place to kind of avoid that.”

Name omitted

“Well you know a lot of guys will say okay as long as we're using a condom... They want to get it and go... But I wonder if it's different for women.”

Name omitted

The one participant that responded no, when asked if he disclosed every time, stated that instead of having to disclose he has made the decision to use a condom every time he has sex. He implied that he would tell his girlfriend and that the level of involvement in the relationship dictates whether he will disclose or not, or whether or not he's going to use a condom; “I don't tell 'em what I have. I always tell 'em 'well, you know, I'm going to use a rubber... And let's just say that neither one of us has to divulge any information to the other. Cause you're not my girlfriend, you're not nothing” (name omitted).

The connection between sex work and safer sex was made by seven of the participants. Particularly noteworthy is the allure of not using protection during sex work in order to earn more money. As Louise (Transgender, age unspecified) highlighted, “Some of the guys will even try to give more money without the condom [if you don’t use a condom]. And I’ve done this for many many years and they try to pay me more and I say ‘no it’s not worth my life... That’s why I’m still alive.’” Kim (Female, age unspecified) stressed, “ You need to be using condoms. I don’t care how much a john [sex work client] tells you he will give you to bareback [do not use a condom] don’t do it, because you just don’t know.”

4.4 Challenges To Sharing Safer Drug Use and Safer Sex Information

Regardless of who they share information with, where they share it, and how they share it, it was clear that there are challenges or conditions that influence the information that is shared. There were many barriers to sharing safer drug use and safer sex information highlighted throughout the chapter; notable barriers include incongruent method of drug use, incongruent drug of choice, fear of disclosing health status, incongruent sexual orientation, and other’s unwillingness to engage in a conversation. There were two additional barriers that impact on how participants shared safer drug use and safer sex information: sobriety and stigma.

4.4.1 The impact of sobriety on sharing information

For the participants that have changed or stopped their drug use, there was a clear indication that how they shared information was different than when they still used. What

happens when participants “sober up” and stop using drugs? Are there social mores that direct how information is shared if an individual is sober? Julie (Transgender, age unspecified) shared that once she stopped using injection drugs, she continued to party with the same group of friends but only drank. Eventually she quit drinking and stopped hanging out with those friends completely; “I was the one that always had the place and people would come and crash, bring their drugs in and alcohol so that’s probably why I don’t really have friends now because I quit! Yeah I got a new batch of friends.” Julie eventually found a new group of friends that did not use drugs. This further supports the notion that information is shared in a natural and organic way; Julie now had friends that did not have conversations about drug use and therefore safer drug use information was not shared. However, Julie indicated that she did continue to share safer sex information as this topic came up in conversation.

Many of the participants that quit using drugs stated that they had to leave their group of friends. The decision to leave was hard but necessary for two principal reasons. The first reason was that when trying to stay *sober* they could not be around the drugs that their friends were using. The participants reported that this was particularly difficult in the beginning when they are trying to quit. It is hard to be around drugs, or people using drugs, without being triggered to use again. In this case, participants that quit said they couldn’t hang around with those friends anymore because their drug of choice was present. The second reason many of them had to leave their group of friends was summed up in what one of the participants went through. He reported that when he stopped using he continued to still hang around with his friends but could no longer share information; “But now they all say ‘Oh don’t try and act like you’re good cause you’re sober.’ ... I’m

not part of that circle anymore” (Name omitted). As Lisa (Female, age unspecified) stated sometimes the friendship comes with ulterior motives and folks that you think are your friends are not there when you sober up, “ ‘Cause they’re not your friends... they always want to argue or want more money for drugs... they only like you because of money and if you don’t have any money, then you’re not their friend.”

4.4.2 The impact of stigma on sharing information.

There is research that suggests that stigma, particularly stigma associated with being HIV positive and/or having a mental health condition (including addictions) can profoundly impact an individual resulting in internalized stigma (Lee, Kochman, & Sikkema, 2002; Livingston & Boyd, 2010). Both external and internal stigma can have an impact on individuals that use drugs as well as within drug using populations (Simmonds & Ross, 2009) which can interfere with prevention and harm reduction activities, such as sharing safer information. Stigma was highlighted throughout all the interviews conducted. There were three categories of stigma identified: stigma associated with using drugs (compounded by the method and/ or drug of choice), being HIV or hepatitis C positive, and stigma of being involved in sex work. Some participants live with one or more of these stigmas on a daily basis which appears to impact whether participants will share information, what information they will share, and who they will share it with.

The first category of stigma had to do with using drugs, which could then be exacerbated by drug of choice and method of drug use. When looking at drug of choice, solvents appeared to be at the bottom of the list and solvent use was associated with the most stigma while cocaine appeared to be associated with the least stigma. Reference to

solvents throughout many interviews included terms like “gross”, “dirty”, “desperate”, and “crazy”. Lisa (Female, age unspecified) shared how she felt when other people judged her for using solvents and the impact it had on her living situation:

“I had a place but I always made myself like I was homeless... I was afraid because people were living there with me and they always preached to me “You shouldn’t.” I didn’t like that so I stayed away all the time, stayed on the streets, slept in the old buildings like sitting underneath where the warm part is there, sleep there with the dust all over me, when I’d come out all dirty... just like I never changed or anything, I never cleaned myself, I was always dirty and nobody liked when I sat beside them because it smells you know, an old moldy person sitting beside you, it’s not good.”

In addition to the type of drug used, method of drug use came with different degrees of stigma. Injection drug use had more stigma associated with it than smoking drugs. Stigma regarding method of drug use was relative to drug of choice (for example, smoking crack was associated with more stigma than smoking marijuana).

The second category of stigma had to do with health status. All participants, whether or not they were HIV or hepatitis C positive, identified stigma associated with both of these illnesses. Stigma associated with status impacted whether participants shared information or not. Some of the participants stated that sometimes they choose not to share information for fear of disclosing their status. They noted that this sometimes resulted in not being able to share information and address behaviours that could result in transmission. It became apparent that the stigma associated with being HIV positive was far greater than that of being hepatitis C positive. Julie (Transgender, age unspecified)

talked about being terrified when she was called back to her doctor's office. She said she was so scared he was going to tell her that she was HIV positive. Her response to finding out she was hepatitis C positive was, "Learning it was hep C wasn't so bad." As the interview progressed, Julie stressed that HIV was the "bad one" to get. Julie had disclosed that she had always used condoms with her sex partners stating that she didn't want to get "sick like her friends". When the research asked her what sickness she was referring to, Julie's response was "like HIV and AIDS and all that." Note that acquiring hepatitis C was not as *scary* as acquiring HIV.

The severity of stigma associated with HIV was shared by one participant. This individual disclosed that he had been diagnosed with both HIV and hepatitis C and his family was only aware of his hepatitis C status. Although he was successfully treated for hepatitis C (and therefore no longer had it) he told his loved ones he was still positive to account for his medical appointments. He was adamant that he did not want anyone knowing that he was HIV positive.

The third category of stigma that was identified in this research was that of sex work. Sex work stigma was identified by participants that did not engage in sex work as well as those that did. Some participants identified their own engagement in sex work as exploitation, which by definition is abuse, yet they still carried stigma and shame over it.

All three of these categories impacted how participants internalized their stigma. Internal stigma, possibly the hardest stigma to deal with, was identified by many of the participants. Participants talked about the way they felt about themselves in relation to their drug use, their addictions, their health status, their gender, and sex work. Charlie (Male, 62) stated he was "being stupid" when explaining how he contracted HIV while

Julie (Transgender, age unspecified) stated “I was 25 years old at the time when I was being stupid.” Lisa (Female, age unspecified) talked about how she looked when she used drugs, her drug of choice being solvents: “I know the way they look on the streets and that's the way I looked. I can't say nothing to them because that was me. I looked terrible.” The impact of internal stigma can affect how individuals share information, but it also affects how they live their lives and engage in other activities. John (Male, 50) talked about not feeling worthy to even have sex with anyone because he is HIV positive: “I just don't have sex because I feel dirty, disgusting, and who am I to go out there and say ‘Hey how are you doing, come home with me.’” The impact of stigma on the sharing of information needs to be further explored.

Chapter 5 – Discussion and Conclusion

5.1 The 595 Peer Working Group Protecting Their Community

“It’s funny, you’ll be sitting there and you can’t help but overhear things and of course you don’t just put yourself in the conversation. But if it’s about hep c or drugs you can’t help yourself... We can help them with that or give them more knowledge. ‘I’m Monica and... we’re just promoting safe drug use’ and what not and we try and always carry something in the car because there’s a lot of people that do IV drugs there ... we try and make it so that we always have a new syringe... and it’s second nature to just make sure.”

Monica, Female, age unspecified

This qualitative community based research project with the 595 Peer Working Group demonstrated that all 17 of the participants are invested in keeping their loved ones and community safe. Sixteen of the participants actively pass on key messages around safer drug use and safer sex. The one participant that answered “no” when asked if she passed on information later stated she “probably talked about it with other people” and specified discussing the topic of using solvents. Furthermore, all 17 participants reported distribution of safer sex and/or safer drug use supplies. Participants identified sharing information in a natural and organic way with the majority stating that information is shared in conversation when drug use or sex comes up; for many, this involved sharing information on a daily basis. Of the 16 that share information, eight reported sharing in a more structured method of delivery including workshops and presentations. Their audiences included service providers, policy makers, people living with HIV and/ or hepatitis C, and other peers. Social media such as Facebook and texting

were identified as ways in which participants also share information. As technology evolves, this is becoming an increasingly popular avenue for sharing information in general.

Where information is shared is largely reflective of how participants spend their days. Wherever their day takes them, drug use and sex comes up in conversations and the participants respond accordingly. Locations in which sharing takes place were at parties, soup kitchens, on the bus, on the street, at home, and at organizations they are accessing. Two participants stated that they structured their day to conduct their own outreach to share information and resources with folks in their community. This is done completely of their own volition. Elliot and Monica stated they often load up with drug use and sex equipment and resources and attend to areas in the city where they know folks are using drugs. Elliot (Male, 42) walked up and down West Broadway and stated that everyone knows him and approaches him for information and resources. As Monica (Female, age unspecified) noted, she loads supplies into her car and goes to the hotels downtown to do outreach.

Participants reported sharing safer drug use and safer sex information within their social networks. Their social networks include family and friends and, for many participants, the sharing of information extended out to include anyone they may spend some time with throughout their day. It was also clear that there are individuals, even within the above categories, that participants would not share information with. For example, one participant reported sharing with family members but stated he does not share information with his mom. When asked if they adapt messages based on who is receiving the information and where and how it is being delivered, all participants made

it clear that they deliver the information in the way that they think will be most beneficial for the recipient. For some, that meant giving everyone the same information. For others, that meant modifying the language or the content based on who was receiving the information (such as children and youth). The underlying concern is always preventing transmission of sexually transmitted and blood borne infections and providing safer options for their loved ones and community members. As noted in Chapter 2, both by Friedman et al. (2007) and the definition of harm reduction, the 595 Peer members are concerned for their well-being as well as the well-being of their communities.

This CBR project shows that participants want to prevent the transmission of STBBI and support safer drug use and sex within their communities. The question then becomes why? Why do they feel the need to share information? Most of the participants' responses to this question support a sense of responsibility to their community. The major theme was that they didn't want their loved ones to go through what they had to go through; whether it is struggling with addictions, living with HIV or hepatitis C, or being exploited. Furthermore, for those that have lost loved ones and community members, they may be motivated by guilt to continue working in this area, "Guilt when he died. I felt terrible. Well I mean he was so young, he was only 21... I wish I could have done something to maybe get him into a detox right away" (Monica, Female, age unspecified).

All the participants identified key messages of safer drug use and safer sex; this includes the participant that stated she does not actively share information. None of the participants touched upon *all* the key messages that were identified during data analysis; however, the majority identified some information that corresponded to each of the six key themes. It is important to note that although participants identified a key message,

that did not necessarily mean that they shared that information; rather, they were clear that some messages they shared and others they knew and practice for themselves. The six themes of safer drug use identified are summarized in Table 5.1 and the five themes of safer sex are summarized in Table 5.2.

Table 5.1 *Key Messages for Safer Drug Use*

Theme	Topic
1. Know your drug(s)	Know what the drug(s) can do to you
	Know your limits (overdose prevention)
	Know how to use your drug(s) properly
	Know how to use your drug(s) in combination with other drugs
	Know the relationship between drug use and sex
2. Drug use equipment	Have your own equipment
	Know where to get your equipment
	Do not share your equipment
	Know how to use your equipment properly
3. STBBI and other infections	HIV/ and hepatitis C transmission
	Other infections (such as abscess)
	Testing
	STI transmission
4. Do not use drugs	Do not use or do not use right now
	Do not use a specific drug
	Use a harm reduction formula
5. How to acquire your drugs	Know your drug dealer
	Know the conditions under which you are purchasing your drugs
	Maintain your drug supply
6. Know who you are using drugs with	Know how drugs impact those you are using with
	Know where and with whom you are using drugs
	Protecting your drugs

Table 5.2 *Key Messages For Safer Sex Practices*

Theme	Topic
1. Use a barrier	Condoms
	Other barriers (such as dental dams)
	How to use a condom properly
2. HIV, STIs and other infections	HIV, STIs
	Other infections (such as cold sores)
	Sex work in relation to STBBI transmission
	Testing
3. Know where to get safer sex supplies	
4. Know your sex partner	
5. Pregnancy	

As Treloar and Abelson (2005) found in their research study, the findings of this research imply that the social network is a natural source of information regarding safer drug use and safer sex. Although Treloar and Abelson (2005) found that 55% of their participants passed on safer drug use information, this research found that all 17 participants indicated that they had passed on some information. It is important to note that the participants are all involved in the 595PWG to address STBBI in their communities and therefore may be more motivated to pass on information.

For participants that injected drugs, initiation of drug use was done with other more experienced injectors (Clair, 1995). Further, some participants stated they either injected or taught others how to inject properly. Peer delivery of STBBI prevention information is instrumental in preventing the spread. This research suggests that peer delivery of information is happening with every new initiation into injection drug use and in some cases with initiation into other drug use. Additionally, this research recommends ensuring peers have up-to-date and accurate information to pass on to their communities.

5.2 Limitations and Considerations

In January 2013, mid-data collection, 14 of the peers participated in supply distribution training. This training involved a one-hour workshop on supply distribution and key messages to deliver when peers are accessing supplies. The 595PWG does distribution to each other during meetings. Key messages include do not share any of your equipment. Following the training, three participants did their interviews. Attending this one-hour workshop may have influenced the key messages that they identified at the interview.

Another consideration in this study was that we did not control for treatment. Although this research explored treatment minimally in the structured questionnaire, it was not thoroughly explored. For those who attended treatment, and for some of the participants that attended treatment more than once, it can be assumed that they received safer drug use information. If this study was conducted again, it would be good to explore how much individuals learned in treatment and how that information interacted with the information they passed on.

Another consideration in this study was coding the structured questionnaires. It was decided during the development of the tools that the questionnaires would not be coded. The rationale for this was that the participants were being asked to disclose their status and the researcher felt that it may affect whether people would disclose this information if they thought they were identifiable. Once the interviews began, it was clear that the participants were comfortable disclosing their status to the interviewer(s).

During data analysis, the researcher realized that it would have been helpful to have the questionnaires coded to help with analysis. If the study is replicated, it would be beneficial to explore the option of coding.

As noted, the researcher had to return to the participants to gather the data on the follow up survey. It would appear that the researcher was not clear as to why she was asking for this new information from the participants. As a result, one individual asked “why are you asking my age?” and another put “older then you.” It is important to be clear as this participant group is suspicious of research and therefore every move made must be transparent and well-explained up front.

One of the major limits to this study has to do with the small and identifiable sample; this resulted in some information having to be excluded from this paper. Some participants are identifiable particularly within their group. As a result, some data had to be left out of the write-up to protect the identity of participants. This occurred twice within this research. In one example, a participant made a great connection between an experience she had and her hepatitis C status. Unfortunately the researcher could not elaborate on this information because the participant’s status would have been disclosed in a way that would easily identify the participant. In other cases throughout this paper, the participants’ information was replaced by “name omitted.” This allowed for the researcher to still use their quotes while protecting their identity. To ensure integrity of this research, there has to be minimal risk for participants. In addition to the initial precautionary measures, such as anonymous participation, the research had to make some decisions to further protect the identity of the participants. It is important to note that if the researcher went to a participant and asked for permission to include potential

identifying information, the researcher assumes that in most cases the participant would grant permission to share it. It is the experience of the researcher that sometimes participants give permission and later on, when life circumstances change, they regret the initial decision. It is with that experience that the researcher decided to exclude any information that could possibly identify someone, rather than ask for permission to share it. The concern is not necessarily that participants can be identified but rather that their health status can be revealed.

5.3 Future Research

There are three major recommendations for future research. The first is to explore the impact that drug of choice and method of drug use have on the sharing of safer drug use information. Although Lisa (Female, age unspecified) identified safer sex and safer drug use messages that individuals need to know, she was clear that she does not actively share information. She stated she carries condoms and if people ask her she will give them some or tell them where to get them but she does not actively share that information. Lisa has the messages yet she does not take the initiative to share. Lisa uses solvents; does this have something to do with the fact that she does not share information? How does her drug of choice influence the fact that she does not share?

Within the context of drug of choice or method of use, it would be valuable to explore if length of involvement in drug use impacts the sharing of information. For example, Erin (Pangender, 40) and Julie (Transgender, age unspecified) stated they were not good at injecting so after a year of trying they quit. Julie stated her friends were the pros and therefore she did not share safer injecting information with them. The question

becomes, does the longer and more “pro” you get with a drug or a method of drug use impact how you share information?

The second major recommendation for future research is to explore the relationship between sex work and the sharing of both safer drug use and safer sex information. The data in this study would suggest that individuals involved in sex work are more inclined to share information. As illustrated in the findings, most of the women engaged in sex work are not HIV or hepatitis C positive, yet they share information. A lot of the folks that started sharing information stated they started sharing after they were diagnosed. These individuals are sharing without a diagnosis. Why is that?

The third recommendation for future research is to explore the emerging trend of social media and how it is impacting how safer drug use and safer sex information is shared. Most of the participants in this research do not have home phones but rather almost all have cell phones. With advancements in technology, individuals can now access social networking sites, including Facebook, at any time on a cell phone. You can have an unlimited number of “friends” that you can instantly send a message to. The result is a more diverse social network, which includes friends, family, acquaintances, and many others (co-workers, school mates, clients). It is safe to say that what constitutes a “friend” is evolving in lieu of social networking sites. All of the participants in this research, with the exception of one, have an account on Facebook and the 595 actively shares information with them on a private group page. Additionally, five participants identified using Facebook for sharing information with others. With options to post information to individuals or for your entire “friends” list, there is an increased opportunity for sharing information instantaneously. It would be beneficial for research to

explore how Facebook is changing the way in which participants both share information and receive information.

5.4 Implications for Policies and Programming

There are two major implications for policies and programming that can be inferred from this research. This includes increasing access to supplies and expanding on education programs to include peer-to-peer knowledge translation and dissemination.

5.4.1 Increase access to harm reduction supplies

As found in this research, access to harm reduction supplies (safer drug use and safer sex equipment) is limited and, all of the participants collect and distribute supplies to their peers. Increasing access to supplies includes increasing the number of supplies that participants can access per visit as well as increasing hours and locations where supplies are available. Increasing use of natural helpers to facilitate distribution may have an impact on HIV and hepatitis C transmission rates. Many participants talked about encouraging their family members and friends to smoke their drugs rather than inject them. By increasing access to crack supplies, there may be a shift in method of drug use, from injecting to smoking (less harmful method).

When looking at the findings of this research, it was clear that risk of transmission does not always deter individuals from sharing under certain circumstances. Monica (Female, age unspecified) identified being so dope sick that she was willing to risk acquiring HIV or hepatitis C, while Kim (Female, age unspecified) stated that “when you’re an addict like that you just want to get that shit into you so bad you know, you

don't care [about sharing equipment].” Another Winnipeg-focused research project supports this finding. Shaw et al. (2007) explored sharing of needles in Winnipeg's injection drug using population and found that sharing needles was dependent on relationships within a drug using network as well as availability of new needles. In light of this, it is important to ensure that new needles are made readily available to prevent the spread of STBBI, particularly HIV and hepatitis C.

5.4.2 Increasing peer-to-peer knowledge sharing opportunities within organizations

A second implication for programming is to incorporate peer-to-peer knowledge sharing into the delivery of education programs involving STBBI information. Another important note that some participants made included organizations not allowing participants to talk about drugs or drug use. The rationale shared for having this policy is that it may trigger other participants that are trying not to use. This is a legitimate argument. The question becomes what is what is more harmful? We know that participants share important information when it comes to STBBI prevention, treatment, and care. They need a safe and welcoming place that is not judgmental that will allow them to share the information that they identify as their responsibility to share. This is in line with what Treavor and Abelson (2005) concluded. They suggested increasing peer education activities, particularly in relation to hepatitis C.

5.5 Conclusion

As the researcher, I have been honored by the participants' willingness to share information with me that is not easy to disclose and often they are fearful of sharing for various reasons. Additionally, I am humbled to be trusted with such sacred information that many participants will never be able to share with anyone else. As the keeper of this information, I will use it respectfully to guide my work and advocate for those who have entrusted me with it. Following every interview I conducted, I was left with a feeling of awe from the information that participants shared with me and I was inspired by the resilience of these participants. Many of the participants I have known for over seven years; this is the first time I was able to sit and just listen to their stories in a non-judgmental and safe space. It was interesting that at the beginning of most interviews, participants were apprehensive and once they "got going", I was shocked by how much they would share.

The impact of hearing these stories has changed me and being able to tell their stories has also changed many of the participants. One participant stated that he felt good being able to tell his story, another participant stated that this is the first time he ever got to really open up and be honest about who he is and what he has been through. Another participant reflected on his interview in a CIHR meeting stating, "I could finally talk about it [drug use] and it felt good to talk about." Another participant stated she was finally being honest about her drug use and her sex life. Yet another stated, "I could never talk about this and today once I started talking you couldn't shut me up." Lastly, another Peer said it was so nice to just talk about it [drug use] openly and honestly. Julie (Transgender, age unspecified) enjoyed this when reflecting on some of her past

experiences, “Like they’d be all high and I’d be sitting there just tipsy watching them and oh my god. Never thought I would be sitting here laughing about it.”

It is clear in this research that keeping their community safe is a priority. It is also evident that some participants go above and beyond the call. These participants noted that they will never be done their work. Elliot (Male, 42) sums up taking care of the community and the limitations of only being able to do so much, “You have to learn to say no. You can only do so much through harm reduction. It’s more than just drugs when you’re working with the public. Sometimes you can get stressed out when people share their stories.”

It is important to reflect on the essence of being a human being and the right for everyone to live a life with human dignity. This notion, human dignity, reverberated through this entire research project. As many of the participants stated so succinctly; “Nobody wants to be an addict or ask anybody who’s an IV drug addict, drug user, and that person will tell you that there’s a piece of them inside that wants them to quit. You know I wish I didn’t have to wake up tomorrow morning and be drug sick and have to fix” (Monica, Female, unspecified). Joe (Male, 41) went on to say, “Based on my own experience, I would hope that the best judge of anyone’s character is themselves.” Now in closing, the words of a participant:

“I’m just me, I’m not rich or famous but I believe that if Nikki Sixx could write a book about his addictive lifestyle maybe my journaling can become a book also.
I’m not rich or famous but I am somebody, a human and my life counts too.”

Kim (Female, age unspecified)

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Appendix A- Letter from Joint-Faculty Research Ethics Board



UNIVERSITY
OF MANITOBA

Research Ethics and Compliance

Office of the Vice-President (Research and International)

Human Ethics
208-194 Dafoe Road
Winnipeg, MB
Canada R3T 2N2
Phone [REDACTED]
Fax [REDACTED]

APPROVAL CERTIFICATE

November 16, 2012

TO: Shohan Illsley (Advisor J. Mignone)
Principal Investigator [REDACTED]

FROM: Wayne Taylor, Chair [REDACTED]
Joint-Faculty Research Ethics Board (JFREB)

Re: Protocol #J2012:181
"What Goes Around: How Peers Use Their Social Networks to Share STBBI
Education and Information"

Please be advised that your above-referenced protocol has received human ethics approval by the **Joint-Faculty Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement (2). **This approval is valid for one year only.**

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

Please note:

- If you have funds pending human ethics approval, the auditor requires that you submit a copy of this Approval Certificate to the Office of Research Services, fax 261-0325 - please include the name of the funding agency and your UM Project number. This must be faxed before your account can be accessed.
- if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.

The Research Quality Management Office may request to review research documentation from this project to demonstrate compliance with this approved protocol and the University of Manitoba *Ethics of Research Involving Humans*.

The Research Ethics Board requests a final report for your study (available at: http://umanitoba.ca/research/orec/ethics/human_ethics_REB_forms_guidelines.html) in order to be in compliance with Tri-Council Guidelines.

Appendix B- Summary of Ethical Dilemma

Good Morning Peers,

I have asked [REDACTED] to facilitate a discussion with you folks regarding the upcoming Community Based Research Project that we will be starting. Please know that I do not have access to the facebook account and will not know who said what. If any questions come forward, [REDACTED] will ask me and she will respond. Once the discussion is done, [REDACTED] will summarize the main details for me and delete it off the facebook account. I am letting everyone know this so that you know you can talk openly and honestly without any concern that I will find out what you said.

The purpose of our current research project is to show that Peers are more valuable then service providers in getting safer sex and safer drug information to the folks that actually need it. I am currently seeking ethics approval to do the research (through the University of Manitoba) and have run into an ethical dilemma that I need feedback from you guys on as it is YOUR research.

The research process includes one-on-one interviews in which you will be asked about:

- What safer sex and safer drug use information do you pass on
- When you pass on safer drug use or safer sex information
- Who you pass it on to

Now the dilemma we are having is who should conduct the interviews. There are two options

Option 1: I, [REDACTED], conduct the interviews.

Benefits of this option include:

- We all have a relationship, which includes respecting your current or historic drug use.
- I value your expertise in issues around drug use and sex
- I have been involved in the process of developing the research with you folks and therefore am aware of the issues

Concerns of this option include:

- As the executive director, I have authority over the PWG. What this means is that I can make decisions that can impact the PWG and the individual members. Ethics has a problem with this because:
 1. If you participate in the research, you might think that if you say something you think I don't want to hear, there may be consequences for you or the group.
 2. You may think that you can only say good things for fear that what you say may impact whether you can do any work for the 595 in the future.

If you choose Option 1 in which I interview you, you need to be informed of the following:

1. I will know what you said as you are saying it directly to me. There will be no consequences outside of the research based on what you said. We will develop a plan to ensure that what is said in the interview will never impact your work on the PWG or at the 595.
2. I will ensure confidentiality. I will not tell anyone else on the PWG, on the research team or in the public who participated and who said what.
3. Your name will never be used in the research. Your interview will be giving a code (for example: 001) and only 001 will be identified on the transcript.
4. I will not expect you to answer any questions you are not comfortable answering
5. In the event of a conflict in the future, I will remove myself from any decision-making regarding you. For example, if there is a conflict within the PWG that involves you, I will not be part of the decision-making regarding that incident. Rather, the project coordinator or the chairs of the 595 will be asked to participate.
6. The research team will be the only people that see the transcript. The PWG will be given a summary of what the interviews found (not specifics but rather themes) to further analyze.

Option 2: Hiring an outside interviewer

Benefits:

1. There will be less of a power dynamic. That individual will have no power over whether or not you participate in the PWG or what your participation in the 595 will be.

Concerns of this option include:

1. You may not know this person or have a working relationship with that individual
2. You may not feel comfortable talking about your current or historical drug use or sex life

If you choose Option 2, you need to be informed of the following:

1. I will not be present during the interviews.
2. All transcripts will still be coded and names will not be used. I will see the transcripts and assist with data analysis. This means that I might be able to identify some folks based on what is said or how it is said.
3. If I do identify you based on your transcript, I will not disclose your name or information to any of PWG members, the research team, or the public.
4. In the event of a conflict in the future, I will remove myself from any decision-making regarding you. For example, if there is a conflict within the PWG that involves you, I will not be part of the decision-making regarding that incident. Rather, the program manager or the chairs of the 595 will be asked to participate.

Also, before anyone participated in the research at all, you will be read a consent form with all the information you are consenting to. You can decide to not participate. Additionally, if you do interview, you will have the option to withdraw your consent at any time in the research.

What we would like from you:

Please provide any feedback or questions you may have to [REDACTED] via the facebook page or her email at [REDACTED] or by phone at [REDACTED]. Please note that I will not have access to any of that feedback. [REDACTED] will compile all the information and summarize it for me. She will not tell me who said what.

Appendix C- Recruitment Process

At the Peer Working Group meeting on September 12, you folks discussed your options for the interviews for the community based research project with [REDACTED].

A 1-hour interview will be done at the office to discuss the information you share with your friends, family, and others around safer drug use and safer sex information. The interview will be recorded and the audiotapes used to type up the interview on a word document (transcript) then it will be destroyed. Your name will not go on the transcript at all. Even if your name or other names are said during the interview, no ones name will go on the transcript. To make sure the transcripts are anonymous (no one will know that you even did an interview or what you said) a fake name will be pulled out of a hat and that is the name that will identify the transcript.

At the end of the interview you will be asked to complete a questionnaire that asked about yourself. It will include questions about your gender, ethnicity, sexual identity, education level, housing situation, income source, HIV/ HCV status, involvement in community and community organizations/ groups.

Here are the 4 options:

OPTION 1: You choose not to be interviewed for the research.

No one has to participate in the interview if they don't want to. It is okay to let [REDACTED] know that you only want to be a part of the research but don't want to do the interview. There will be no consequence for not doing the interview and no one on the research team will know that you didn't do the interview.

OPTION 2: [REDACTED] interviews you

Shohan will do the interview with you alone. No one else will be there and everything you say will stay between you and [REDACTED]. [REDACTED] will not tell anyone what you said. [REDACTED] will transcribe the interview and then destroy the audiotape so no one will hear what you said.

OPTION 3: [REDACTED] and (Name, Organization) will interview you.

[REDACTED] and Name will interview you together. No one else will be there and everything you say will stay between you, [REDACTED] and Name. [REDACTED] and Name will not tell anyone what you said. [REDACTED] will transcribe the interview and then destroy the audiotape so no one will hear what you said.

OPTION 4: Name, Organization will interview you.

Name will do the interview with you alone. No one else will be there, not even [REDACTED]. Everything you say will stay between you and Name. Name will transcribe your interview so no one, not even [REDACTED] will know what you say. Name will then destroy the audiotape so no one will hear what you said. Name will then give the transcript to [REDACTED] for analysis.

To book your interview or to talk to [REDACTED] about your options you can:

1. Call [REDACTED] at the office at [REDACTED]
2. You can come to the office to talk to [REDACTED]
3. You can inbox her on Facebook at Peer Winnipeg

Appendix D- Consent Form

***What Goes Around: How Peers Use Their Social Networks
To Share STBBI Education and Information.***

Consent Form

WHAT IS THIS PROJECT ABOUT?

As a research for the community based research project, you are invited to take part in a 1-hour interview. The purpose of this study is to learn about how the 595PWG members share information, resources, and tools regarding STBBI prevention with friends, family, partners, and others.

WHO ARE THE PEOPLE RUNNING THIS PROJECT? HOW CAN I CALL THEM?

This project belongs to the 595PWG. [REDACTED] (Executive Director, The 595) is helping to gather the data and interpret what is in it. [REDACTED] can be reached at [REDACTED]. [REDACTED] (Research and Evaluation Coordinator, SERC) is also helping with the research and she can be reached at [REDACTED]

WHAT WILL HAPPEN DURING THE PROJECT?

We are holding one on one, 1-hour interviews with each researcher from the 595PWG that signed up for an interview. You signed up with [REDACTED] to have the following interviewer (s)

I/ We will be asking questions about sharing STBBI information, such as:

- ☐ Do you share safer drug use information with anyone?
- ☐ Do you share safer sex information with anyone?
- ☐ Why do you share information?
- ☐ How and when do you share information?

You will be asked to complete a questionnaire at the end of the interview that will ask you about the following:

- ☐ Gender, ethnicity, sexual identity, education level, housing situation, income source etc.
- ☐ Where you receive your information about HIV, HCV, safer drug use and safer sex.

The interviews will recorded on an audio recorder with your permission. The interviewer (s) will also record some notes. Your name will not be put on any of the papers. Even if your name or someone else's name is said during the interview, it will not be written down. The audio recordings will be transcribed in a word document and your name will not be on the transcript. The audio recordings will be destroyed once this is done. You will be asked to draw a fake name out of a hat and that name will be used to identify your transcript.

WHAT ARE THE BENEFITS OF THIS PROJECT?

We believe that this project will help understand the processes in which STBBI information is shared. You will receive \$20 and 2 bus tickets at the end of the session for participating in the interview. The data will be analyzed by the research advisory team and then presented back to the researchers for further analysis and feedback. In consultation with the researchers, a final report will be produced and the 595PWG will develop a dissemination plan for the results. The plan includes providing the results to inform and improve program development at the organizations that serve the 595PWG.

WHAT ARE THE RISKS OF BEING PART OF THIS PROJECT?

Taking part in the project should not put you at risk for physical harm. If after your interview you feel upset and need to talk to someone, please feel free to contact any of the following:

Klinic Community Health Centre Crisis Line- 204-786-8686
Nine Circles Community Health Centre- 204-940-6000
Sage House – 204-943-6379

If you already have someone you talk to, I would be happy to make sure you have his or her contact information before you leave.

WILL PEOPLE KNOW WHO TOOK PART IN THE PROJECT?

To make sure what you say is **confidential**, we will not use your real name or other identifiable information anywhere in the transcripts, notes, or any other reports. All information will be kept in a locked file drawer in The 595's office at 595 Broadway Ave. and electronic files will be password protected. Only [REDACTED] will have access to the transcripts. Audiotapes will be destroyed upon verification of transcripts. By July 31, 2013 the consent forms, questionnaires, and transcripts will be destroyed.

Canada has laws that protect children. If, during the interview someone talks about abuse of a child, or someone who needs special care, that is happening right now, or is being planned, the researchers must report the incident to the appropriate authorities. Abuse means things like physical harm, or severe emotional harm or neglect.

DO PARTICIPANTS HAVE TO ANSWER EVERY QUESTION? CAN PARTICIPANTS QUIT THE PROJECT WHENEVER THEY WANT?

Your participation is **voluntary**. You also do *not* have to answer *any* of the questions asked during the interview or on the questionnaire. You are free to stop the interview at any time, for any reason. You have the right to quit the project at any time. If you choose not to answer any questions or stop the interview there will be no negative effects on any services you may be receiving now or may receive in the future. If you wish to stop the interview, please let the researcher know, and she will immediately stop. You are also free to ask any questions regarding this consent form.

HAS THIS STUDY BEEN APPROVED BY A GROUP THAT MAKES SURE THE STUDY PARTICIPANTS ARE TREATED FAIRLY AND PROTECTED FROM HARM?

Yes. The Joint Faculty Research Ethics Board at the University of Manitoba has approved this project. If you have questions about your rights as a participant in this study, or are not satisfied at any time with any aspect of this study, you may contact

by phone at or by email at

. You do not need to give your name.

The University of Manitoba may look at the research records to see that the research is being done in a safe and proper way.

FOLLOW UP INTERVIEWS

There may be follow up interviews to help us understand the daily experiences of communicating STBBI information. Do you consent to being contacted for a follow up interview?

If yes, sign your name here:

If no, sign your name here:

I am fully aware of the nature of this project and have agreed to participate in it. I have read (or had it read to me), understood and been given a copy of this consent form.

Sign your name here _____ Date _____

Signature of Person Obtaining Consent

_____ Date _____

Appendix E- Interview Guide

What Goes Around: How Peers Use Their Social Networks To Share STBBI Education and Information.

Interview Guide

The following are a sample of the questions that may be asked during the one hour face to face interview.

1. What do you consider to be key information on drug use that people should know?
2. Do you share safer drug use information with anyone?
 - a. Who do you share it with?
 - b. Where do you share information?
 - c. What kind of information do you share?
 - d. How do you share information?
 - e. Is there anyone that you do not share information with? Why not?
 - f. Is there any safer drug use information that you do not share? Why not?
3. What do you consider to be key information about sex that people should know?
4. Do you share safer sex information with anyone?
 - a. Who do you share it with?
 - b. Where do you share information?
 - c. What kind of information do you share?
 - d. How do you share information?
 - e. Is there anyone that you do not share information with? Why?
 - f. Is there any safer drug use information that you do not share? Why not?
5. Do you adapt or change how you share information based on who you are sharing with?
 - a. Why?
 - b. Do you have an example?
6. When or why did you start sharing information?
7. Is there anything else you would like to say in this interview?

Appendix F- Structured Questionnaire

What Goes Around: How Peers Use Their Social Networks To Share STBBI Education and Information.

Questionnaire

The following are questions regarding you. Please answer to the best of your ability.
Remember you do not need to answer questions that you are not comfortable answering.

1. What is your gender? (circle)

Male Female Transgender Pangender Other: _____

2. What is your sexual identity? (circle)

Heterosexual Gay Bisexual Other: _____

3. What is your ethnicity/ culture/ heritage? (circle)

Aboriginal Caucasian Other: _____

4. What is your highest level of education? _____

5. What is your current housing situation? (circle)

Homeless Squatting Using a shelter Couch surfing
Renting Own my house Other: _____

6. What is your current living situation? (circle)

Alone With roommate(s) With family Other: _____

7. What is your main source of income? (circle all that apply)

No income Social Assistance (Welfare) Sex trade Drug trade
Part time employment Full time employment Other: _____

8. Please circle if you have any of the following: (circle all that apply)

HIV/ AIDS

Hepatitis C(HCV)

Co-Infected with HIV & HCV

Mental Health

None

9. Where did you get your information about **HIV, Hepatitis C, Safer Drug Use, Safer Sex Practices?** (check all that apply)

Source	Check	Source	Check
Pamphlets		Partners	
Street Connections Van		Friends	
Safer Drug kits		Family members	
Drug Treatment Centres		Schoolmates	
Outreach Workers		Co-workers	
Counsellor/ Support worker		Partying friends	
Doctors or nurses		Acquaintances	
School Teacher		Dealers	
Distribution site		Peer groups	
Other: _____:		Other: _____	

10. Are you involved in any other groups listed below?

Yes (if Yes, please list all groups below)

No

Peer Based Groups:

Organizations:

Coalitions/ Working Groups:

Other:

Appendix G- Follow Up Questionnaire

Follow up Descriptive Questions
What goes around!

Code:

1. How old are you: _____
2. What age did you start doing drugs/ solvents?

3. If you stopped, at what age did you stop doing drugs/ solvents?

4. Did you ever start doing drugs/ solvents again? Yes No
5. What drugs/ solvents did you do when you started again?

6. What is your current “drug of choice”?

7. What age did you start drinking alcohol?

8. Have you consider your alcohol use problematic at any time? Yes No

Please fill out the table below: Start with the drugs you tried first

[illegible]

Appendix H- Grocery List Activity

Purpose of the activity:

1. To help explain why we do data analysis
2. To explore the process by which we do data analysis in a qualitative study

Facilitation Notes:

What is data analysis?

- Basically the process of taking all of the information and figuring out what does it mean.
- Data collection is getting the information, data analysis is figuring out what the data means.

Why do we do it?

- Usually we are trying to answer some specific questions. The main question is: how do peers use their informal social networks to share information?
- To prove an idea, or disprove an idea
- Usually with research we have kind of an idea of what we think the research will tell us. Sometimes the data analysis supports that, sometimes it does not.
- It's helpful because it gives some more information and also can be very influential in things like program direction, policy change, and advocacy.

How do we do it?

Group similar ideas together. Can be helpful to count.

Grocery List:

Frozen supreme pizza
2L Milk
2 x cans of tuna fish
Strawberries
Loaf of bread

Bag of Oreos
Peach Yogurt
Package of Hotdogs
3 x boxes Kraft Dinner
1 jar of mayonnaise

Discuss with the group different ways that the grocery list could be sorted (example: by food groups, by fresh food vs. frozen food, by food packaging such as can, bag, etc).

Have the group choose one method and sort the list accordingly. Discuss the process and any items that were different to categorize. How do we deal with these items?

Appendix I- How Well Do You Know Your Peers?

How well do you know your Peers?

1. Of the 17 Peers who did the first survey, how many identified as Aboriginal or First Nations?

a. 17 of the 17 Peers	b. 13 of the 17 Peers
c. 11 of the 17 Peers	d. 8 of the 17 Peers

2. Of the 14 Peers who did the second survey, what age group do you think is the most common?

a. Most of the peers are in their 20's	b. Most of the peers are in their 40's
c. Most of the peers are in their 30's	d. Most of the peers are in their 50's

3. Of the 17 Peers who did the first survey, how many people do you think are currently renting (the place they stay)?

e. 5 of the 17 peers are renting	f. 12 of the 17 peers are renting
g. 9 of the 17 peers are renting	h. 16 of the 17 peers are renting

4. Of the 14 Peers who did the second survey, what do you think is the average age that folks started using drugs/solvents?

a. 13 years old	b. 15 years old
c. 16 years old	d. 18 years old

5. Of the 14 Peers who did the second survey, how many people said that weed is one of their current drugs of choice?

a. 9 out of the 14 use weed currently	b. 13 out of the 14 use weed currently
c. 5 out of the 14 use weed currently	d. 3 out of the 13 use weed currently

Why are we doing this?? Excellent question. Information like this is often used when the results of a research project are written up.

For example, a report might say something like (this is a made up example): "In this research project, we interviewed 20 people. The age range of the people was between 22 – 35 years. Most of the participants (60%) identified as Aboriginal or First Nations."