Healthy Sexuality and Harm Reduction/Street Connections Nursing Outreach

Winnipeg Blood Borne Infection Outreach Clinics – May-October 2019 Report

Background

Beginning in 2017, a significant shift in the epidemiology of the syphilis outbreak in the Winnipeg Health Region (WHR) occurred. What had historically been an outbreak amongst Men who have Sex with Men (MSM), transitioned to the current outbreak which is now predominately representative of a heterosexual network, with an associated increase of unprecedented proportions. Characteristics common to the population currently impacted by syphilis include history of/ current incarceration, intravenous drug use and unstable housing. Because the burden of infection is impacting a very disadvantaged population, case and contact follow-up requires additional time and traditional methods of outbreak management such as contacting people by phone or through home visits appear to be less effective.

Outreach testing clinics have been conducted at inner city locations where networks of individuals may have been exposed to STBBIs, with a focus on syphilis testing. Clinic locations were informed largely by trends identified in case review by Healthy Sexuality and Harm Reduction public health nurses (PHN).[1] Individuals who lived in or frequented these residences or sites were considered as transient and frequently lacking access to (sexual/BBI) health care.

Outreach Testing Model

A Public Health Nurse and an Outreach Worker organized and managed the clinics.[2] This allowed for the majority of the paperwork to be done by the Outreach Worker, leaving the nurse to focus on engaging with clients for testing. An "on-call" nurse was also available for support with clinical decisions as needed during the clinic.

Some outreach clinics operated on a "pop-up" model. The Street Connections van would discretely pull-up at the location and staff would offer services to those approaching the van. In most cases a sign outside the van, on the sidewalk, would indicate that BBI testing was available.

Other testing clinics occurred in partnership with community agencies. For instance, HSHR collaborated with Ka Ni Kanichihk as part of the National HIV Testing Day. Most series of testing clinics were done in partnership with the Downtown and Point Douglas Public Health teams and local shelters, incorporating

[1] Usually these trends would have been identified from data systematically collected in forms associated with case and contact management, i.e., NSTI. However, changes to the form and its supporting electronic system, PHIMS, have made it almost impossible to record or extract these data in a timely fashion.

[2] A few times, as part of their orientation to public health, new PHNs assisted during the clinics.

STBBI testing within a larger array of services (e.g., harm reduction supply distribution, flu clinics, etc.). Other testing sites were identified based on locations where clients testing positive for STBBIs mentioned having met sexual partners during their STBBI investigations.

At the time of testing, clients were given a centralized number to call to get their results and instructions to call back in 2 weeks or to drop-in to 496 Hargrave or approach the Street Connections van for their results.

Evaluation

The outreach clinic evaluation sought to answer the following questions:

What is the reach of the testing clinics? Are we targeting a population that wouldn't access healthcare normally?

Specific questions and indicators:

- How many people attend?
  - Number of people tested;
  - Number and proportion of people never tested before.
- What is the positivity rate?
  - Number and proportion (%) testing positive
  - Amount testing positive compared to amount tested
- What is the awareness of syphilis among client participants? i.e., "have you heard of syphilis?" "what?"
- Why test through outreach clinics?
  - Reported reason for attending clinic, i.e., "Why did you decide to come?"
- What are barriers for testing elsewhere? i.e., "Have you ever received testing before?" "Where?" "Why do you not go there?" "Is there anything stopping you from accessing health care?"
- What other pressing issues are of concern? i.e., "what is the most pressing issue in your life at the moment?"

Are outreach testing clinics a good investment? Does this approach make financial sense?

- Amount of worker hours (PHN/OW) compared to positive results.

The PHN would collect data of testing and treatment offered at each site. As part of the clinics, PHNs asked participants if they would anonymously volunteer to participate in a short survey. The survey covered the above mentioned indicators and items.

Findings

Beginning late-May 2019, the Healthy Sexuality and Harm Reduction team conducted 11 clinics. A PHN-Outreach Worker team would conduct most of the clinic. Later in October, new PHNs supported the clinics as part of their orientation to HSHR work. The locations frequented were: 75 Martha St. (Main Street Project), 650 Main St., 222 Furby St. (West Broadway Ministry), 740 Maryland, 2 additional locations associated with temporary encampments, Agape Table, Siloam Mission, and 765 Main Street (Ka Ni Kanichihk, as part of National HIV Testing Day).

What is the reach of the testing clinics? Are we targeting a population that wouldn't access healthcare normally?

11 outreach clinics were conducted, with 105 people tested – mostly for blood-borne infections. During clinics, clients had access to condoms, information about STBBIs (with a focus on syphilis), and occasionally Naloxone training.

STBBI positive results were found at each clinic. Of the 105 people tested, 37 clients tested positive for at least one STBBI. This shows an overall **positivity rate of 35%.** When considering **infectious syphilis**, a priority infection, the positivity rate was **8.5%.**

Test Results

Hepatitis C	19
Syphilis	9 infectious / plus, 2 resolved
Syphilis/Hepatitis C	1
GC/CHL	5
GC/CHL/Syphilis	1

Treatment

For 13 of the 16 people who were in a position to receive treatment, PHNs were able to provide immediate treatment onsite or reconnect and treat within a two week-period.[3] Of the remaining, two became aware of their infection but were not treated at that time, and another one (co-infected with hep C) was not able to be contacted. A few were treated with assistance from Winnipeg Fire Paramedic Service Community Paramedics at Main Street Project.[4] Therefore, **81.5% of new cases were treated**.

Of the 20, hepatitis C cases, 10 were followed-up and referred for treatment. Two persons with hepatitis C were not able to be connected with. One person refused follow-up and referral information.

[3] Two cases of syphilis were historic, and did not require follow-up.

[4] As result of this experience, HSHR is working more closely with WFPS in order to connect clients with public health or access timely treatment.

Hepatitis C Case Management

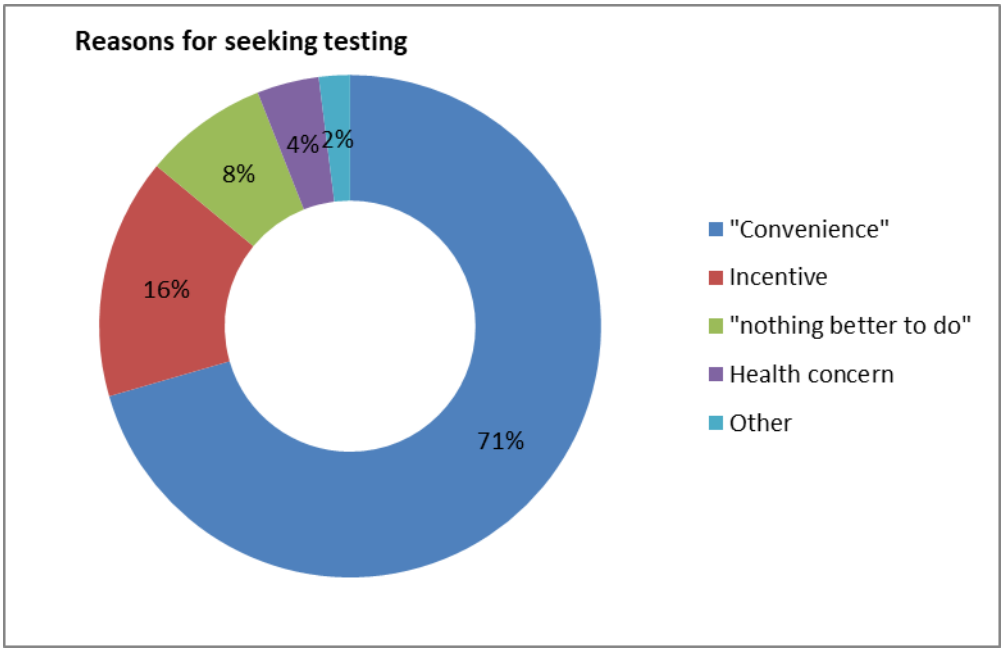
Contacted and referred	10
Contacted and refused follow-up	1
Unable to connect for follow-up	2
Historic hepatitis C – follow-up no needed	2
Missing information	4

Survey Results

The survey was offered whenever appropriate. Staff asked participants at the **largest outreach clinics** (n=7). The analysis is based on the number of participating clinics. Of 84 people accessing testing, 51 responded to the short questionnaire. This represents a **61% response rate.**

Reason for attending/seeking testing

Most respondents indicated that they attended the clinic because it was "convenient" (n=36). Several (n=8) named the offering of a monetary incentive as a reason (i.e., Ka Ni Kanichihk provided $5 for responding to a short survey as part of HIV testing day). A few (n=4) said that they had "nothing better to do," or had seen the news about syphilis/health concern (n=2). One respondent indicated that they "trust(ed) Street Connections."



Thirty nine percent of the respondents indicated that they had never been tested for a STBBI before. Of those who had tested before, 32% (n=10) accessed testing from their own physician, 19% (n=6) did not recall where, 16% (n=5) were tested while incarcerated, 9.5% (n=3) by paramedics at MSP (only

tested for HIV/POC), 6.5% (n=2) at Access Downtown, 6.5% (n=2) Street Connections, 3% (n=1) at Nine Circles, 3% (n=1) at Red River Clinic, and 3% (n=1) as a pre-requisite for immigration purposes.

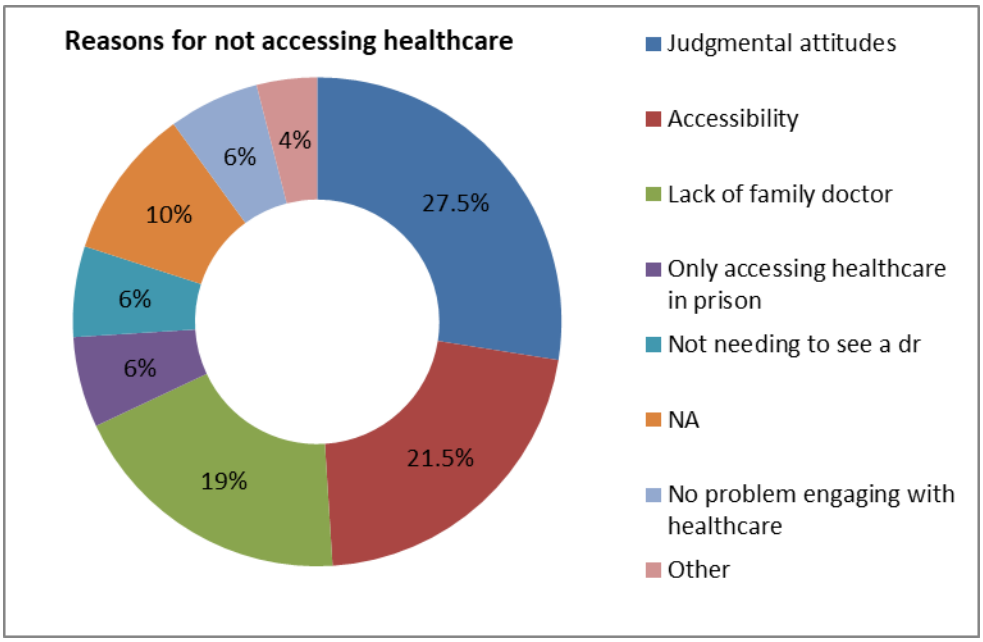
Reasons for not accessing testing

Participants were then asked for any **reason for not going back for testing to these locations** (except those who had tested while incarcerated or tested for immigration purposes). 35% of participants provided a reason for not returning. The main reasons for not going back to these locations were:

- **judgmental attitude** to drug use (4)
- **location** (3)
- inability to keep appointments
- banned from facility due to violence/behavior

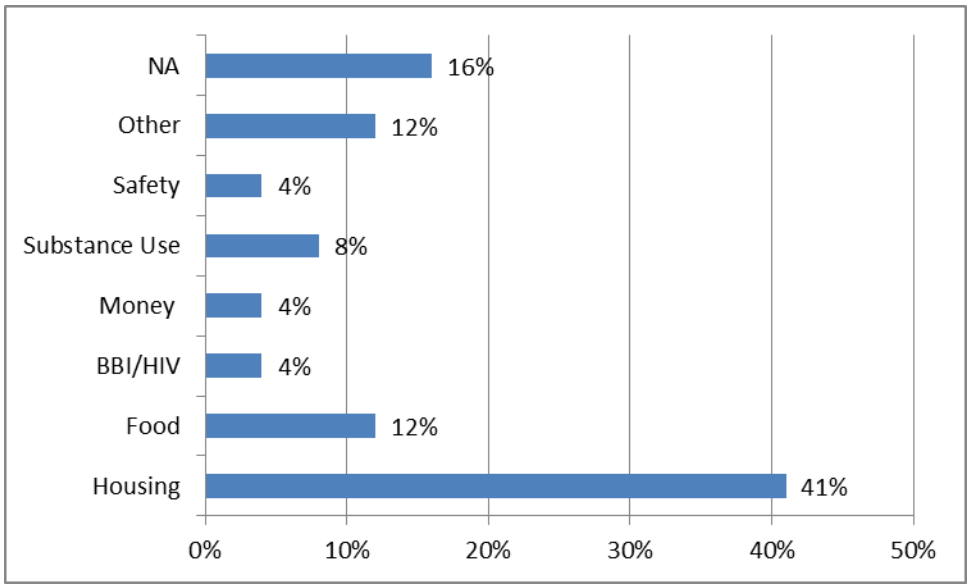
Reasons for not accessing healthcare

We further asked of **any reason stopping them from accessing healthcare** in general. Three (6%) clients indicated that there were no reasons for stopping them from accessing healthcare. Among the rest, over **a quarter** of the respondents (14/27.5%) reported not engaging with healthcare due to **judgmental attitudes of providers**. For most, this related to providers' attitudes towards substance use. Others said lacking trust of providers, in general. This was followed by 21.5%/11, who indicated that location or timing of the appointments were not convenient (e.g., "not open at night", "can't keep appointments", convenience). 19.5%/10 did not have a family doctor. Other reasons were: accessing only healthcare when incarcerated (3/6%); not needing to see a doctor (being healthy) (3/6%); not having health card (1); no response (10%/5).



Most pressing issues in participants' lives

Not surprisingly, housing was reported as the most pressing issue for respondents. Forty one percent of the participants cited housing as their priority concern. This was followed by a distant 12%, who mentioned food as a priority issue. Substance use (4/8%), safety (2/4%), money (2/4%) and concerns over BBI/HIV (2/4%) were key matters for some. Other issues raised were: political climate, transportation, religion, children, lack of ID/papers.



Knowledge of syphilis

Finally, we inquired about syphilis awareness. While most have heard about syphilis – 36/70.5%, there were still **29.5% of respondents who had not heard of Syphilis**. Most of those who had heard of this infection believed that it was a **common infection** (e.g., "everyone has it"). This was followed by about a third of the respondents who believed that syphilis was **not curable**. Other things people had heard were that it was transmitted through needles, and that it had negative outcomes ("goes to the brain"). A few simply stated having been treated for syphilis in the past.

Are outreach testing clinics a good investment? Does this approach make financial sense?

Most clinics ran between 3 to 4 hours (half-day). Therefore, the estimated time that staff spent during clinics was estimated at 45 hours. **On average we were able to connect with 1.2 STBBI cases per outreach hour**. Considering the positivity rate, the fact that most people have been treated (including many on site at the time of the clinic), that many of these people would not have presented for STBBI

testing, STBBI outreach clinics in locations where people may face significant barriers to care appeared to be a good investment.[5]

Closing Comments

Outreach clinics facilitated access to testing and treatment to populations disproportionally affected by STBBIs. STBBIs focused clinics or integrated with other care (i.e., flu shots) were equally well received, as were HSHR/Street Connections led or those led by community partners.

These clinics improved partnerships with relevant WRHA public health services, and community agencies. It also jumpstarted enhanced communication with WFPS concerning testing, follow-up and treatment of clients in common and those who are not well connected to primary care.

Increased accessibility and a harm reduction approach (e.g., non-judgmental, "meeting people where they are at") facilitated testing and treatment. This matched clients' reports on deterrents in accessing healthcare services. Emphasis on describing HSHR team as Street Connections rather than as undifferentiated WRHA employees was deemed key to establishing and maintaining trust with clients during the clinics.

Healthcare providers' attitudes towards substance use, and location and timing of services or the system of appointments play a key role in the STBBI outbreak response. Compounded to this were pressing issues that in fundamental ways affect people's health such as access to housing and food. As long as such structural determinants of health are not resolved we will continue to observe significant rates of STBBIs among people residing in the core area of Winnipeg.

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[5] Time used to complete other testing related tasks, and contact follow-up are missing from this report. Further consideration to these tasks would render a fuller picture of HSHR outreach testing and its overall public health impact.