ATTACHMENT 15
"PLANNING AND CONDUCTING STREET OUTREACH PROCESS EVALUATION"

Planning and Conducting Street Outreach Process Evaluation

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Introduction

In collaboration with four organizations currently conducting street outreach to multiple client populations at risk for HIV and other sexually transmitted diseases, the AIDS Evaluation of Street Outreach Projects (AESOP) has developed a primer for process evaluation information collection. The purpose of this guidance is to assist street outreach programs to consistently collect a core set of information items that can be used to evaluate and guide street outreach services. The information can be used to assess program implementation procedures to inform and improve street outreach service delivery. The guidance addresses process information collection for three (3) specific street outreach activities: **active street outreach, fixed-site outreach,** and **drop-off site outreach.** Organizations are invited to use this guidance and sample information collection instrument formats. The formats should be modified as needed to fit the specific characteristics, goals and objectives of individual organizations.

The number of organizations providing street outreach services to persons at risk for HIV has grown steadily since the onset of the AIDS epidemic *(World Health Report, 1992)*. Practical experience has enabled many street outreach organizations to enhance their program development and delivery, and street outreach workers have improved their skills of risk assessment and service provision. As a public health strategy, street outreach has proven to be a very effective means of accessing those persons who are often defined as "hard-to-reach" with important health information and risk reduction materials *(Freudenberg, 1989)*.

Outreach workers provide services to persons where they are, in their natural settings. They serve as links between programs and communities *(National Institute on Drug Abuse, 1993)*. In addition to city sidewalks and busy street corners, these natural settings often include injection drug user shooting galleries, crack houses, convenience stores, liquor stores, soup kitchens, hotels, highway rest-stops, abandoned subway tunnels, shade-trees, and video arcade rooms. The risk reduction services provided by street outreach organizations enable persons to begin the process of reducing their personal risks for HIV infection and other sexually transmitted diseases (STDs) immediately, right where they are.

However, as an intervention delivery method, street outreach is not necessarily limited to HIV and STD prevention only. Street outreach can bring a variety of health education services and information to persons who find access to clinic- and institutional-based services difficult. Because street outreach reduces barriers to health care, it may be an appropriate strategy for addressing the prevention of heart disease, hypertension, tuberculosis, and drug use *(Jenkins, 1980)*. Street outreach can provide important information about nutrition, immunization, and maternal and child health to large groups of people who might not otherwise have access to this information. In addition, street

outreach workers frequently provide referrals and assistance to other social services such as shelter, food, and drug treatment. Street outreach affords public health providers the opportunity to circumvent programmatic barriers created by waiting lists for treatment and inaccessible clinic hours. Clients are not asked to come to the program, instead the program goes to them.

Street outreach organizations are not monolithic. They vary significantly according to client populations, program objectives, and services provided. Yet, needs assessment, program development, program implementation, and program evaluation are all common program elements that the more successful street outreach organizations usually share. The Centers for Disease Control and Prevention document, "Planning and Evaluating HIV/AIDS Prevention Programs In State and Local Health Departments" *(Academy for Educational Development, 1993)*, lists five (5) types of program evaluations. They are **formative evaluation, process evaluation, outcome evaluation, impact evaluation**, and **economic evaluation**. The authors describe **formative evaluation** as a means of gathering information that organizations may use to modify and refine their intervention activities to enhance services and achieve program objectives. Formative evaluation/research conducted prior to program development and implementation is often referred to as **needs assessment. Process evaluation** documents the intervention effort and provides information to reassess and change service delivery techniques. Process measures may also be included in formative evaluation activities. **Outcome evaluation** is defined as a measurement of whether or not a program activity has actually achieved its stated objectives. **Impact evaluation** assesses the effect when an organization's program objectives are achieved. In the case of HIV/AIDS prevention, an impact evaluation question might be "Did Intervention X succeed in reducing HIV/AIDS morbidity and mortality rates?" Finally, the authors write that **economic evaluation** utilizes a variety of methods to measure the cost of a program as a function of the consequence/outcomes achieved by it.

Each of these types of evaluation are important for measuring the effectiveness of street outreach *(Valdiserri, 1989)*, but outcome, impact, and economic evaluations can be very resource intensive, and therefore not easily administered by many organizations conducting street outreach. There are a variety of formative evaluation methods e.g. health education, ethnographic, or social work *(Green and Lewis, 1980; Coyle, Boruch, and Turner, 1991; Cox, Erlich, Rothman, and Tropman, 1984)*. Organizations will need to identify the most appropriate formative method based on their individual program capacity.

Perhaps the most basic type of evaluation--and for many street outreach organizations the most *do-able*--is process evaluation. Process evaluation provides description that details what was done, to whom and how, and when and where. Based on an organization's stated goals and objectives, it can provide a fundamental assessment of how well the organization is implementing program activities *(Coyle, Boruch, and Turner,*

1991). Process evaluation plays a critical role in improving the delivery of services, and although it is not an assessment of whether or not a program is *effective*, if done correctly it can provide a solid foundation on which an organization may design and implement outcome measurement. To know how well an intervention *works*, an organization must first know how well it is being *delivered*. Program management requires knowledge, judgement, and flexibility.

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Three Types of Street Outreach Activities

Although there are a variety of street outreach organizations, most of the outreach activities fall into three (3) basic categories. They are:

Active Street Outreach

> *outreach workers moving down a street, screening and engaging prospective clients for the purposes of delivering risk reduction information, materials, and/or referrals*

Fixed-Site Outreach

> *outreach activities which are conducted at a specific place within a given location (e.g., setting up at table on a corner or working out of a mobile van or storefront)*

Drop-off Site Outreach

> *outreach activities which provide risk reduction supplies to volunteer distributors who may then distribute these items to persons involved in risk behaviors (e.g. brochures left at a check-out counter or bleach kits distributed at an injection drug user "shooting gallery)*

Active Street Outreach is usually location specific, occurring within a few blocks radius or within a specific neighborhood. During **fixed-site outreach**, outreach workers may invite persons whom they have engaged in the street to come to the site or place for more in-depth assessment discussions and/or service delivery, based upon client needs or interests. While activities associated with **active street outreach** may be part of the **fixed-site outreach** effort, the primary focus of intervention is at the fixed site. **Drop-off site outreach** refers to the provision of risk reduction supplies to volunteer distributors who then distribute these items from specific locations such as hotels used by commercial sex workers, convenience stores, or injection drug user (IDU) shooting galleries. Again,

while some **active street outreach** may also occur during these **drop-off site** visits, the primary focus of the activity is the delivery of supplies to the volunteer distributors.

It is recommended that a basic, limited, and relevant set of information items be recorded each time street outreach is completed at a designated location. A suggested list of items includes: the date, period of outreach, outreach location, client population, team identification, team size, type of outreach, number of volunteer contacts, number of client contacts, service provision, and print materials distributed. *(See also section, **Suggested Information Items**).* Although the information items are the same for each type of street outreach activity, the items should be collected separately for the three defined activities, because they have different and important program implications.

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The Contact and the Encounter

The essential element of all street outreach activity is contact with the client. Client contact may be active, e.g., during **active street outreach** and **fixed-site outreach**, or it may be more indirect, e.g., during **drop-off site outreach.** Volunteer distributors make the contact with clients during drop-off site outreach. Access to clients to provide them with health promotion and risk reduction information and materials is the *primary* reason why organizations take their interventions to *the street (Freudenberg, 1989).* Street outreach programs are constantly seeking ways to increase the frequency and enhance the quality of their contact with clients in the community. Good process evaluation is essential to guide these efforts.

When outreach workers are new to a neighborhood or setting, they may find their interactions with the client population are very brief. Perhaps these interactions will consist of no more than providing a client with a brochure and a condom. Even though this kind of contact may not be especially rewarding, it is nevertheless important. Street outreach workers must build credibility with client populations.

Many organizations seek to establish instant credibility by hiring, as outreach workers, persons who are from the communities these organizations are planning to serve, such as gay men, recovering injection drug users, or former commercial sex workers. This is generally a good practice. These persons often know the haunts and hang-outs of the client population. They can *talk the talk and walk the walk.* However, it is important to remember that the ability to be an empathic provider is not universal to all *(Hepworth, Larsen, 1993).* Past relationships are necessarily changed, when roles are different. A period of adjustment for all is to be expected. Even *indigenous* street outreach workers

need to allow time for their *new clients*, although they may be *old friends*, to get to know them in their new positions and appreciate the services they can now provide.

Over time, street outreach workers who have worked regularly in a particular neighborhood or setting will find that many of their interactions with clients will last longer and have more content. Many will even be repeat contacts. Outreach workers and clients may even come to know each other by name. Professional helping relationships *(Hepworth, Larsen, 1993)* between outreach workers and clients will develop. What was originally a brief **contact** develops into the more substantial **encounter.** For the purposes of this document, the contact and the encounter are defined as follows:

Contact:

> *face-to-face interaction during which materials and/or information is exchanged between an outreach worker and a client (or small group of clients)*

Encounter:

> *face-to-face interaction that goes beyond the contact to include focused assessment, specific service delivery in response to the client's identified need(s), and a planned opportunity for follow-up*

Although every contact will not necessarily lead to an encounter, every encounter does begin with a contact. Some programs will want to collect more information during street outreach activities. Individualized risk behavior information and specific service delivery, including the kinds of referrals made, *are* very important process information. But to collect this kind of information, outreach workers may have to go beyond the **contact's** simple face-to-face provision of materials/information to what has been defined as the **encounter.**

Ambitious process information collection forms are often cumbersome to complete, because they tend to presume that every street interaction between an outreach worker and a client is an encounter. In reality, most interactions are usually contacts. Pressure to *fill in all the blank spaces* may lead outreach workers to make *guess-timates* to come up with the numbers. In some situations, less really is more.

The guidance provided in this document is intended to help programs collect more reliable process information about the street outreach **contact.** At an aggregate level, this kind of information will enable street outreach programs to answer the questions: "*Who* was served, and *what* was the service?" This kind of information is imperative for street outreach intervention development and delivery. In addition, process evaluation

information accurately collected for the **contact** can then facilitate the development of refined process measures for the **encounter.**

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Organizing Street Outreach

To conduct good process evaluation of street outreach, it is important that organizations establish basic structure for conducting street outreach. The following five steps are suggested as an outline for structuring street outreach activities.

STEP 1: **PLAN** outreach activity.
STEP 2: **PREPARE** for outreach activity.
STEP 3: **COORDINATE** specific outreach locations and activities.
STEP 4: **KEEP SEPARATE RECORDS** for each outreach activity.
STEP 5: **DEBRIEF** at the end of the field visit.

STEP 1: **PLAN** outreach activity for each day.

Street Outreach Programs are encouraged to hold brief outreach team meetings daily to plan the day's (or night's) activities. These meetings allow teams to prepare adequately for their activities. To properly plan for outreach activities, outreach workers will need to consider client population characteristics for each outreach location to be visited. Gender and age distribution, prevalent risk behaviors, "drug of choice", and "people traffic", are just some of the possible issues that influence decisions about time to conduct outreach, materials needed, team composition, and suitable outreach activity. In addition, weekly outreach planning meetings provide crucial opportunities to discuss and implement relevant formative evaluation findings that can improve service delivery.

It is important to designate outreach locations that are easily managed by the outreach workers for their intervention activities. One of the fundamental objectives of formative evaluation or needs assessment for street outreach activities should be to identify locations where the client population can be accessed *(O'Reilly, Higgins, 1991)*. Once these locations are determined, they can be identified on a map. Active street outreach sites, fixed-sites, and drop-off sites should be identified on the program's outreach activity map. Unique codes for each location and site activity should be assigned and recorded on the map. They may also be kept on a confidential master list. **However**, it is

important to remember, many of the locations will involve illicit activities by clients; and clients, as well as entire communities, have rights to confidentiality. Coding (e.g., Location A, instead of the street name or address) can protect clients, communities, and outreach organizations.

STEP 2: **PREPARE** for outreach activity.

What supplies and how many/much is needed for each outreach activity and location should be determined before outreach teams go to the field. To accomplish this, outreach teams will need to anticipate the number of prospective clients they expect at each location. They may also want to **package** the materials if pre-packaging is appropriate. Estimates of what and how many supplies needed for drop-off site outreach activities should also be determined before going to the field. In advance, outreach workers may want to prepare special drop-off site packets for their distributor volunteers. *(Of course during a drop-off site visit, active street outreach can also occur with clients who are gathered at a drop-off site. When this happens, the number of client contacts and the number of materials provided should be included in the drop-off site outreach report.)* Each outreach team member should do a careful inventory to get an accurate count of all items (e.g. condoms, bleach kits, and/or referrals cards) that s/he will need for outreach before departing to the field.

If an outreach project elects to use **packaging**, it is recommended that materials be organized in allotments for each outreach location. This will enable easier counting of materials after outreach in one location is complete or before or during movement to the next outreach location and activity. Street outreach programs should develop and maintain consistent **material distribution patterns**. If outreach team members agree on these patterns and are *committed* to maintaining them, condoms, bleach kits, and/or brochures can serve as indirect measures for the number of client contacts made during a period of street outreach. *(See also section, "Keeping Count")*

STEP 3: **COORDINATE** specific outreach locations and activities for the day.

Outreach teams should know where they are going, approximately when they will arrive, and when they will leave each location. They should share this information with office staff, especially with outreach supervisors. If appropriate, outreach teams are also advised to designate a time for returning to the office *before* they depart for field activity. A "check-in" time might also be established, when outreach workers can call in from the field to leave or

receive messages.

STEP 4: **KEEP SEPARATE RECORDS** for each outreach activity.

After a specific outreach activity, process evaluation information is best recorded before moving on to the next designated location. Separate records enable more accurate descriptions of specific activities by individual outreach location.

NOTE: *Safety must always be considered when recording information in the field. In some situations, it may be appropriate for outreach workers to return to their cars or proceed to some other neutral location to record process information. When recording information, a balance has to be struck between accuracy that immediacy may afford and worker safety that delay can provide. (See also section,* ***Keeping Count****)*

STEP 5: **DEBRIEF** at the end of the field visit.

Outreach programs are encouraged to schedule regular debriefings with outreach workers and supervisors. Because some programs do not require outreach workers to return to the office at the end of street outreach activity, debriefings should be scheduled based on an individual program's needs. Whether they are held daily or weekly, it is important that debriefings be a regular part of the street outreach program. Debriefings provide opportunities for outreach workers to review and discuss the number of client contacts, and information and materials delivered according to the information recorded on the process information collection forms.

In addition to the accounting review, it is also important for outreach teams to review the day's (or night's) outreach events. Staff may need time to grieve, support, celebrate, or just *think out loud* about what they may have seen and done during their time in the field. Debriefing can provide a safe place for outreach workers to *vent*, thereby reducing the strain on personal lives and the occurrence of worker burn-out. Debriefings are important opportunities for outreach workers to learn from and support each other.

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Suggested Information Items

(For Active Street, Fixed-Site, and Drop-Off Site Outreach)
Organizations conducting street outreach are urged to develop evaluation plans that are appropriate to their program's interventions, objectives, and resources. Again, many organizations conducting street outreach will not have resources to conduct outcome, impact, or economic evaluations. These evaluation activities may be more readily conducted by organizations involved in evaluation research. While formative evaluation can be less resource-intensive, the variety of methods available for conducting this kind of evaluation has to be considered. Organizations providing street outreach should decide carefully which evaluation type best suits their program's activities and resources.

For the purposes of street outreach process evaluation, it is suggested that street outreach workers collect the following information items. This recommended list is not meant to be exhaustive, but basic and brief. The items are generally attainable by outreach worker observation and are not dependent upon client response. Some items can even be recorded by outreach teams before they go into the field.

Information Items List

DATE-- the date of street outreach activity

PERIOD OF OUTREACH-- period of time during which street outreach activity occurs

OUTREACH LOCATION-- specific location where street outreach occurs (e.g., unique code or identifier)

CLIENT POPULATION-- the specific client population to be targeted for street outreach activity at a given location

TEAM I.D.-- unique code or identifier for a specific street outreach team

TEAM SIZE-- number of street outreach workers composing the street outreach team

TYPE OF OUTREACH-- description of street outreach activity (e.g., active, fixed-site, or drop-off)

VOLUNTEER CONTACTS-- total number of volunteer distributors (e.g., convenience store operators, hotel managers, and shooting gallery operators) contacted by a street outreach team

CLIENT CONTACTS-- total number of clients contacted resulting in delivery of service (information, materials, or referrals) during street outreach activity, including appropriate and relevant demographics (e.g., gender, ethnicity, and/or age)

SERVICE PROVISION-- any service (information, materials, or referrals) provided by street outreach worker to a client during street outreach activity

PRINT MATERIALS DISTRIBUTED-- number by type/title of pamphlets, brochures, or fliers distributed during street outreach activity

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Keeping Count

While accurate information collection is vital to conducting good process evaluation of street outreach activities, street outreach workers are not likely to regard evaluation with the same enthusiasm as service delivery *(Weiss, 1972; Lewis and Lewis, 1983)*. When one is committed *to getting the word out and saving lives,* sometimes *the numbers just don't mean much*. Lengthy or complicated forms may make the collection of numbers even less inviting. The process evaluation of a service should never distract from the actual delivery of that service. Process evaluation is meant to measure, inform, and improve street outreach not to hinder or supplant it. To this end, two (2) different, although complementary, methods for **keeping count** are recommended to count the number of persons being served by street outreach and to track the kind of services that are being provided. They are the **Indirect Method** and the **Direct Method.**

The Indirect Method

Street outreach workers may use the number of condoms, bleach kits, or brochures they distribute as indirect measures for the total number of client contacts. When using the **Indirect Method,** it is critical that outreach workers establish a **materials distribution pattern** and adhere to it carefully. (See section, ***Organizing Street Outreach***). The indirect method can provide a good **approximate** number of client contacts based on the number of materials distributed (e.g., brochures, condoms, or bleach kits). In many instances, clients will want more or less of a given item. Sometimes, they will ask for bleach kits for their friends. Other clients may make persuasive cases for more condoms than the standard allotment. Previously contacted clients may decline the offer of another information brochure, although they want the condoms or the bleach kits. The indirect method of measurement also does not provide demographic information about the client contacts. For these reasons, using this method will not always permit outreach workers to get an **exact** count of the number of client contacts, although the number of risk reduction materials distributed may be accurately counted in this manner. The Indirect Method provides a surrogate measure of client contacts only.

The Direct Method

Especially with respect to demographic information, street outreach workers frequently

make *guess-timates* that are subject to increased personal bias. The **Direct Method** of counting can reduce and even eliminate this problem. Since this method does not rely upon the number of materials distributed as a surrogate measure of client contacts, it also improves accuracy by counting the actual client contacts.

This method involves the use of small note cards on which outreach workers record by hatch mark (|) basic information about the persons contacted during street outreach activity. Each outreach worker carries a small (e.g., 3 X 5) note card during street outreach. At designated time intervals (e.g., 30 or 60 minutes), the workers pause briefly to record by hatch marks in the designated boxes the number of contacts. The boxes may be organized in categories according to ethnicity relevant to an agency's objectives. Typically, these categories might include Latino, African American, or White. Thus, if an outreach worker contacted 10 White females during a period of outreach activity, then s/he would make 10 marks in the demographic box labeled "White F". (See Figure One)

Figure One: ***Sample Format***

Date:	**Location:**		**OW Initials:**
Latino M	**African American M**	**White M**	**Other M**
Latino F	**African American F**	**White F** ||||| |||||	**Other F**

Some street outreach organizations may determine that other demographic information is necessary. The boxes may be organized around age, language spoken, or risk behavior. However, the note card should also be kept *basic* and *brief*. It is important for the information to be *outreach worker-observable* as much as possible. The measured entity is still the **contact**. During the contact, outreach workers do not normally ask clients detailed demographic questions. The emphasis is usually on the provision of risk reduction materials and information. In most instances, ethnicity information collected during the average street outreach contact will reflect outreach worker observation and inference. As this is often true for age as well, it is recommended that age ranges be used rather than exact years.

Deciding What Works Best

Outreach organizations are encouraged to choose counting methods that suit their programmatic needs. Street outreach worker input is essential for making these decisions. Many times, process evaluation designs are developed in *the office* by *administrative staff.* Yet, it is the *outreach worker* who is responsible for collecting the information on *the street.* While evaluation expertise is important, street savvy is also critical. At face value, the **Direct Method** may always seem to be preferable. However, in some settings, outreach workers cannot take even the shortest notes, because of threats to their safety. In these situations, the **Indirect Method** is a viable alternative, despite the loss of some accuracy. In street outreach, there must always be a balance among service, evaluation, and safety.

The **Indirect Method** should yield an accurate count of the number of brochures and risk reduction materials that were distributed during a specific outreach period. Good preparation techniques will enable outreach workers to also know the titles and types of brochures and materials being distributed. This information is critical for good service delivery. To be effective service providers outreach workers need to know what the client population wants and needs. The **Direct Method** improves the accuracy of client contact numbers. It also enhances the quality of demographic information that is recorded. Coupled with the **Indirect Method**, the **Direct Method** will enhance the overall quality of process evaluation for street outreach. However, compromise may have to guide program evaluation decisions when determining what is the most appropriate counting method. Finally, with either of these methods, it is probably easier to make total counts immediately following the outreach activity in each specific location before moving to the next location.

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Process Information Collection Forms

To conduct process evaluation, an organization is required to develop some kind of evaluation instrument for recording street outreach activities. Although organizations are encouraged to develop forms tailored to their own specific programmatic needs, it is recommended that *any* street outreach instrument be kept basic and brief, and *street outreach* worker-friendly. Evaluation can and should take place in the settings where the service is delivered. This is true in the case of street outreach too. However, just as the outreach worker *dresses* for the field, so too must the evaluation type, method, and recording instrument.

Included in this document are two sample formats that organizations are invited to use in the development of their own process evaluation forms for street outreach activities. The first format is the "STREET OUTREACH ACTIVITY REPORT". (See Figure Two). It is presented on a single, standard 8.5 X 11 page, but it can be reduced to a smaller size. The format includes all of the items that were suggested earlier in the section, ***Suggested Information Items***. It may be used to record process information counted by either the **Indirect** or **Direct** Methods. At the end of this document, the format is shown as a completed report for three process evaluation examples. In the first two examples, **Active and Fixed-Site Outreach,** the **Indirect Method** of counting is used. The third example involves **Drop-off Site Outreach.**

The second format is for the Direct Method note card. (See Figure Three) The recommended size of the note card is 3 X 5. In the sample format shown, the categories are organized along ethnicity and gender, but street outreach organizations should design the format according to their individual programmatic needs.

Figure Two: *Sample Format*

STREET OUTREACH ACTIVITY REPORT

DATE	TEAM I.D.
PERIOD OF OUTREACH	TEAM SIZE
OUTREACH LOCATION	
CLIENT POPULATION	

TYPE OF OUTREACH: **(circle one)**

ACTIVE STREET FIXED SITE DROP-OFF

VOLUNTEER CONTACTS: **(list site types)**

_____ TOTAL

CLIENT CONTACTS:

_____ TOTAL

GENDER:
_____MALE _____ FEMALE

ETHNICITY:
_____ AFR.AMERICAN
_____ LATINO
_____ WHITE
_____ OTHER

SERVICE PROVISION:

_____ SINGLE CONDOMS
_____ BLEACH KITS
_____ OTHER MATERIALS
_____ REFERRALS **(specify)**_____

PRINT MATERIALS DISTRIBUTED:

(title) (number)

_____ _____

_____ _____

_____ _____

Figure Three: ***Sample Format***

DIRECT METHOD NOTE CARD

Date:	**Location:**		**OW Initials:**
Latino M	**African American M**	**White M**	**Other M**
Latino F	**African American F**	**White F**	**Other F**

Planning and Conducting Street Outreach Process Evaluation

Glossary of Terms

Active Street Outreach-- outreach workers moving down a street, screening, and engaging prospective clients for the purposes of delivering risk reduction information, materials, and/or referrals

Contact-- face-to-face interaction during which materials and/or information is exchanged between an outreach worker and a client (or small group of clients)

Direct Method-- involves the use of small note cards on which outreach workers record by hatch mark (I) basic information about the persons contacted during street outreach activity

Drop-off Site Outreach-- outreach activities which provide risk reduction supplies to volunteer distributors who may then distribute these items to persons involved in risky behaviors (e.g., brochures left at a check-out counter, or bleach kits distributed at an injection drug user "shooting gallery)

Economic Evaluation-- to measure the costs/inputs of street outreach activity as a function of the consequences/outcomes achieved by organizations conducting street outreach

Encounter-- face-to-face interaction that goes beyond the contact to include focused assessment, specific service delivery in response to the client's identified need(s), and a planned opportunity for follow-up

Formative Evaluation-- to assess program activity for the purposes of informing and improving the ongoing development and delivery of services

Helping Relationship-- an interaction between an outreach worker and a client aimed at assisting the client to regain equilibrium and achieve growth in coping capacity by developing new resources or employing untapped resources in ways that reduce tension and achieve mastery of problems

Impact Evaluation-- to assess a program's effect on a problem as a result of the program achieving stated objectives

Indirect Method-- using the number of condoms, bleach kits, brochures, or other items distributed as a surrogate measure for the total number of client contacts

Materials Distribution Pattern-- distributing information, risk reduction materials, or other items according to a specific plan that includes quantity and content

Needs Assessment-- the process of obtaining and analyzing information from a variety of sources in order to determine the needs of a particular client population or community

Packaging-- organizing information, risk reduction materials, and/or other items in separate sets of specified quantity and content to facilitate distribution

Process Information-- specific items of information collected for the purposes of conducting process evaluation

Outcome Evaluation-- to measure whether a particular intervention has had a desired impact on the client population; whether the intervention provided has made a difference in knowledge, attitudes, beliefs, behaviors, or health outcomes

Outcome Objective-- the desired outcomes, impact, results, or performance level for a program

Process Evaluation-- to provide a descriptive assessment of a program's implementation activities; to assess what was done, to whom, and how, when, and where

Process Objective-- the specific step or strategy that must be achieved in order to implement a program; the defined means for achieving the outcome objective

Volunteer Distributor-- a person who voluntarily distributes information or risk reduction materials from their place of business or operation (e.g., hotel managers, shooting gallery operators, or convenience store operators)

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Process Evaluation Examples

What follows are examples of the three identified street outreach activities complete with a process information collection report prepared for each example. These are **only** examples. The examples utilize the **Indirect Method** of keeping count to demonstrate how the surrogate measures of contacts can be calculated and reported. The **Direct Method** was illustrated earlier in this document under the heading ***Keeping Count.***

Active Street Outreach

On May 21, 1993, Team ALPHA (team of **2**) carries 200 single condoms packaged by 4 (**50** packs), **200** brochures, and **50** bleach kits (each containing: 4 condoms, 1 oz. bottle of bleach, and 1 oz. bottle of water). They go to Location X, a predominantly Latin neighborhood where injection drug use is known to occur. They will be targeting Latin IDUs and their sex partners. The team will work for an afternoon (1-5 p.m.) to conduct active street outreach.

Outreach worker (OW) #1 carries:	**50 condom packs,** **100 brochures, and** **25 bleach kits**
At 5 p.m., OW #1 has left:	**15 condom packs,** **8 brochures, and** **12 bleach kits**
So, OW #1 distributed:	**35 condom packs (140 singles)** **92 brochures** **13 bleach kits**

If the **distribution pattern** is **4** single condoms **OR 1** bleach kit (as appropriate) and at least one brochure per person *(no one would get both single condoms and bleach kits)* and one brochure, then the number of person contacts could be calculated as follows: the total number of person contacts is **92; 44** persons received information only; and **48** persons received information **AND** risk reduction materials (condoms and bleach kits).

OW #2 carries:	**50 condom packs,** **100 brochures, and** **25 bleach kits**
At 5 p.m., OW #2 has left:	**11 condom packs,** **0 brochures, and** **6 bleach kits**
So, OW #2 distributed:	**39 condom packs (156 singles)** **100 brochures** **19 bleach kits**

If the **distribution pattern** is **4** single condoms **OR 1** bleach kit (as appropriate) per person *(no one would get both single condoms and bleach kits)* and one brochure, then the number of person contacts could be calculated as follows: the total number of person contacts is **100**; **42** persons received information only; and **58** persons received information **AND** risk reduction materials (condoms and bleach kits).

OW #1 saw 92 persons. She estimates that 28 were Latina women, 56 were Latino men, and 8 were White men.

OW #2 contacted 100 persons and estimates that 40 were Latino male contacts, 15 were African American male contacts, and 4 were White males. He also thinks he contacted 41 Latina women.

The report would read as follows: (See Figure Four)

Figure Four: *Sample Format*

STREET OUTREACH ACTIVITY REPORT

5/21/93	DATE	Alpha	TEAM I.D.
1-5 p.m.	PERIOD OF OUTREACH	2	TEAM SIZE
Loc. X	OUTREACH LOCATION		
IDU	CLIENT POPULATION		

TYPE OF OUTREACH: **(circle one)**

(ACTIVE STREET) FIXED SITE DROP-OFF

VOLUNTEER CONTACTS: **(list site types)**

0 TOTAL

CLIENT CONTACTS:

192 TOTAL

GENDER:
123 MALE 69 FEMALE
ETHNICITY:
15 AFR.AMERICAN
165 LATINO
12 WHITE
____ OTHER

SERVICE PROVISION:

296 SINGLE CONDOMS
32 BLEACH KITS
0 OTHER MATERIALS
0 REFERRALS **(specify)**_____

PRINT MATERIALS DISTRIBUTED:

(title)	(number)
"Women and AIDS" (Spanish/Eng)	88
"IDUs and AIDS" (Spanish/Eng)	32
"Safer Sex and STDs" (Spanish/Eng)	192

Fixed-Site Outreach

Teams Alpha and Omega (2 persons per team) are working together on the corner of Avenue Y and Z Street, a new area for outreach activity. They are targeting young adults in a predominantly African American neighborhood to provide risk reduction education and STD/AIDS testing and treatment referrals. They set up an information table. While Omega Team works the block, Alpha maintains the table. They will conduct the activity from 3-6 p.m.

Outreach Worker #1 on the Omega Team distributes **70** condoms **(5 condoms per person)** and **30** "Safer Sex" brochures **(1 per person)**. However, not everyone took both items. OW #1 describes his contacts as all African American. Fourteen persons took condoms; 7 were men, and 7 were women.

Outreach Worker #2 on the Omega Team distributes **60** condoms **(5 condoms per person)** and **26** "Safer Sex" brochures **(1 per person)**. As with OW #1, OW #2 also had people who did not want both condoms and brochures. She also records all her contacts as African American and notes that she provided condoms to 2 men and to 10 women.

Alpha Team (Outreach Workers #3 and #4) distribute **100** condoms **(5 condoms per person)** and **115** "Safer Sex" brochures **(1 per person)**. In addition, they also make **7 testing/treatment referrals** to the local health department, using health department STD clinic referral cards, which will enable bearers of the card to get expedited clinic appointments. Alpha Team records that 13 women and 7 men came to the information table and received condoms. They also note that all the STD clinic referrals were made for men. As with the Omega Team, all the clients were African American.

In this example, more people took brochures than took condoms. It may also be true that some who took condoms declined brochures. In addition, some persons also received referral cards. This situation represents a common occurrence in street outreach and demonstrates one of the weaknesses of the Indirect Method. Since outreach workers tend to repeat visits to sites, clients may have already received information/brochures and may only require risk reduction materials (e.g., condoms, or bleach kits). While some persons are willing to accept a pamphlet, they may be too embarrassed to take condoms. In some cases, outreach activity may focus primarily on referral/recruitment into treatment services. In these situations, it is recommended that outreach workers decide by consensus which service delivery item will serve as the surrogate measure for the number of contacts, because this will determine the number of client contacts recorded. In many cases, condoms or bleach kits may be appropriate; in some instances, print materials (e.g., brochures or referral cards) may be more suitable. What is most

important is that the surrogate measure or measures be agreed upon by the entire team and adhered to by all.

If the Alpha and Omega Teams decide to use the number of condoms as the surrogate measure for the number of client contacts, then the *fixed-site* report would be completed as follows: (See Figure Five)

Figure Five: *Sample Format*

STREET OUTREACH ACTIVITY REPORT

5/22/93 DATE	Alph/Omg TEAM I.D.
3-6 p.m. PERIOD OF OUTREACH	4 TEAM SIZE
Loc. Z OUTREACH LOCATION	
adults CLIENT POPULATION	

TYPE OF OUTREACH: (circle one)

ACTIVE STREET (FIXED SITE) DROP-OFF

VOLUNTEER CONTACTS: (list site types)

0 TOTAL

CLIENT CONTACTS:

46 TOTAL

GENDER:
16 MALE 30 FEMALE
ETHNICITY:
46 AFR.AMERICAN
____ LATINO
____ WHITE
____ OTHER

SERVICE PROVISION:

230 SINGLE CONDOMS
0 BLEACH KITS
0 OTHER MATERIALS
7 REFERRALS (specify) STD Clinic

PRINT MATERIALS DISTRIBUTED:

(title)	(number)
"Safer Sex"	171

Drop-off Site Outreach

The Omega Team (2 persons) make their weekly visits to five hotels where commercial sex workers (CSWs) engage in sex in exchange for money and drugs. All the hotels are located in Neighborhood A.

The hotel "managers" are committed to HIV risk reduction and provide clean bleach and condoms to the CSWs and their customers. Many of the female CSWs have questions about women's health issues in general. One of the managers also keeps a locked needle receptacle in the leasing office. She encourages IDUs to deposit old needles/syringes into the safe receptacle. The Omega Team keeps the key to this receptacle and replaces the receptacle weekly.

The team conducts their visits during the morning hours, a time that they have determined, based on field observation, to be *quiet* with respect to drug use and prostitution activity. To each hotel *drop-off site,* they provide **100** condoms, **10** bleach kits, and **25** AIDS, **50** sexual health, and **10** drug treatment brochures. At the one hotel, they also leave a new needle receptacle and remove the old one. Other than the usual interaction with the volunteer distributors, no other significant client contact occurred.

For this activity, their process information collection report would be as follows: (See Figure Six)

Figure Six: *Sample Format*

STREET OUTREACH ACTIVITY REPORT

5/24/93	DATE	Omega	TEAM I.D.
10-1p.m.	PERIOD OF OUTREACH	2	TEAM SIZE
Loc. A	OUTREACH LOCATION		
CSW	CLIENT POPULATION		

TYPE OF OUTREACH: **(circle one)**

ACTIVE STREET FIXED SITE (DROP-OFF)

VOLUNTEER CONTACTS: **(list site types)**

5 TOTAL (Commercial Sex Worker Hotels)

CLIENT CONTACTS:

0 TOTAL

GENDER:
_____MALE _____ FEMALE

ETHNICITY:
____ AFR.AMERICAN
____ LATINO
____ WHITE
____ OTHER

SERVICE PROVISION:

250 SINGLE CONDOMS
50 BLEACH KITS
1 OTHER MATERIALS (needle receptacle)
_____ REFERRALS **(specify)**_____

PRINT MATERIALS DISTRIBUTED:

(title)	(number)
"AIDS"	125
"Sexual Health for Women"	150
"Drug Treatment"	50

About the Pilot

The guidance presented in this document was developed in collaboration with four organizations currently conducting street outreach: the Association for Drug Abuse Prevention and Treatment (New York, New York); the Harris County Health Department STD/HIV Program (Houston, Texas); the Massachusetts Department, AIDS Bureau (Boston, Massachusetts); and the University of Illinois School of Public Health (Chicago, Illinois). These organizations represent community-based organizations, state and local health departments, and research institutions. They serve a variety of urban client populations whose behaviors put them at risk for HIV and STD infection, including: injection drug users, crack cocaine users, persons who exchange sex for drugs/money, homeless persons, and youth in high-risk situations.

Eight street outreach workers (two per site) were trained in the process evaluation methods described in this document. They implemented the methods for a 6-week period in the fall of 1993. Feedback from the field was generally positive. Outreach workers valued the recommendations regarding street outreach organization. One agency, however, chose to hold only weekly debriefings, because their workers do not routinely return to the office at the end of the day. Most of the workers reported that the methods increased the quality of their contact accounting. Some preferred the **Indirect Method** to count contacts, but others found that the **Direct Method** was easily implemented.

Although the pilot generally went well, two difficulties were encountered. First, outreach workers reported that the accuracy of their contact counting was reduced when they were involved in situations where clients clustered around them--a situation not uncommon to street outreach. As noted earlier, it is important to remember that *the streets* are usually very active places, and outreach workers are frequently faced with completing multiple tasks simultaneously. Therefore, in the words of one of the outreach workers, when conducting street outreach process evaluation, it is recommended to "Keep it simple."

The second problem involved the recording of process evaluation information in the field. At one site, clients were so concerned about the information that workers were recording, that they followed the outreach workers to their car to see what was being written. Again, this speaks to the need for keeping process evaluation methods simple. It also suggests an example of when the Indirect Method may be preferable to the Direct Method.

The sample format for Keeping Count was reproduced on both regular copier paper and 3 X 5 index cards. In general, the index cards were favored by the street outreach workers. Some carried the cards on clipboards. Others chose to carry the cards in their pockets.

The eight outreach workers met with their supervisors regularly to discuss the progress of the pilot, and they provided essential feedback from the field. Many of their suggestions were implemented immediately, and all of their recommendations are reflected in this final document.

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References

Academy for Educational Development. (1993). Planning and Evaluating HIV/AIDS Prevention Programs in State and Local Health Departments: A Companion to Program Announcement #300 (AIDS Communication Support Project, Centers for Disease Control and Prevention #200-91-0906), (pp. 5-6). Washington, DC: Johns Hopkins University.

Cox, F. M., Erlich, J. L., Rothman, J. & Tropman, J.E. (1984). Tactics and Techniques of Community Practice (pp. 41-55). Itasca, Illinois: F. E. Peacock Publishers, Inc.

Coyle, S. L., Boruch, R. F., & Turner, C. F. (1991) Evaluating AIDS Prevention Programs (pp. 53-61; 66-71). Washington, D.C.: National Academy Press.

Freudenberg, Nicholas. (1989). Preventing AIDS: a guide to effective education for the prevention of HIV infection, (pp. 125; 139-150). Washington, DC: American Public Health Association.

Green, L. W. & Lewis, F. M. (1986). Measurement and Evaluation in Health Education and Health Promotion (pp. 27-34). Palo Alto, California: Mayfield Publishing Company.

Hepworth, Dean H. & Larsen, JoAnn (1993). Direct Social Work Practice: Theory and Skills (pp. 92-113; 30- 51). Pacific Grove, California: Brooks/Cole Publishing Company.

Jenkins, R.S. (1979, July). The impact of health education on Black communities without changes in the external environment. Paper presented at the meeting Health Education and the Black Community, sponsored by the Centers for Disease Control and Prevention, Atlanta, Georgia.

Lewis, J. A. & Lewis, M. D. (1983). Management of Human Service Programs (pp. 15-18). Monterey, California: Brooks/Cole Publishing Company.

National Institute on Drug Abuse. (1991). Community-Based AIDS Prevention (DHHS Publication No. ADM 91-1752) (pp. 9-10). Washington, DC: U.S. Government Printing Office.

O'Reilly, K. R., & Higgins, D. L. (1991). AIDS community demonstration projects for HIV prevention among hard-to-reach groups. Public Health Reports, 106(6), (pp. 714-720).

Valdiserri, Ronald O. (1989). Preventing AIDS: The Design of Effective Programs, (pp. 246-264). New Brunswick: Rutgers University Press.

Weiss, C. H. (1972). Evaluation Research: Methods of Assessing Program Effectiveness (pp. 92-109) Englewood Cliffs, New Jersey: Prentice-Hall, Inc.

World Health Organization. (1992). Outreach: a potentially effective intervention approach to people practising high-risk behaviors, (pp. 1-6). Geneva, Switzerland

Additional Readings

AIDS Outreach Committee. (1988). Community Street Outreach Guide. (Publication No. 17,139-122-1000-5-92-1.34-C.R.). Boston, Massachusetts: Massachusetts Department of Health.

CDC. (1993). Assessment of street outreach for HIV prevention--selected sites 1991-1993. MMWR, 42(45), (pp. 873-880).

Dyal, William W. (1990). Program management: a guide for improving program decisions, Atlanta, Georgia: Centers for Disease Control and Prevention.

Fernando, M. Daniel, (1993). AIDS and Intravenous Drug Use Westport, Connecticut: Praeger.

Peele, S. & Brodsky, A. (1991). The Truth About Addiction and Recovery. New York: Simon and Schuster.