

EVALUATION OF THE ALBERTA COMMUNITY HIV FUND

**ASSESSING THE OUTCOMES OF THE
2001-2004 FUNDING CYCLE**

November 2005

Submitted to:

Public Health Agency of Canada

Submitted by:



Acknowledgements

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List of Acronyms

Acronym	Complete Wording
ACCH	Alberta Community Council on HIV
ACHF	Alberta Community HIV Fund
AHW	Alberta Health and Wellness
AIDS	Acquired Immune Deficiency Syndrome
CAANS	Central Alberta AIDS Network Society
HANSEAA	HIV/AIDS Network of South Eastern Alberta Association
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IDU	Injection Drug Use
KAF	Kimamow Atoskanow Foundation
MSM	Men who have Sex with Men
NPNU	Non-Prescription Needle Use
PHAC	Public Health Agency of Canada
PLWH	People Living With HIV
STI	Sexually Transmitted Infection
U2	Unwilling or unable to prevent the spread of HIV/AIDS
WBHAS	Wood Buffalo HIV & AIDS Society

Executive Summary

Background

The Alberta Community HIV Fund (ACHF) was implemented in 1999/2000 as a joint community, federal, and provincial initiative. Two categories of funding are available under the ACHF: operational funding and project funding. Operational funding is available to fund programming, key positions within an organization, and overhead and administrative costs. Voluntary, non-profit, non-governmental organizations whose principal mandate is community-based HIV programming are eligible for operational funding. Project funding is available to fund time-limited (one year only), specific activities that address unmet needs and priorities relating to HIV. The ACHF is administered by the Alberta Community Council on HIV (ACCH), a partnership of fifteen non-profit, community-based HIV organizations.

Purpose

The purpose of the 2001-2004 fund cycle evaluation was to analyze and interpret data in relation to the evaluation questions outlined in the Alberta Community HIV Fund Provincial Evaluation Framework and to summarize data according to each of the five fund approaches.

Methods

The data collection methods included a focused document review and key informant interviews. In addition, ongoing communication was conducted with fund representatives as necessary to raise questions and clarify issues during the data collection and analysis phase.

Key Findings

Creating Supportive Environments

Operationally-funded organizations and project sites contributed to public awareness, perceptions, attitudes, and knowledge of HIV through an extremely high volume of reported activities such as public presentations, awareness campaigns, educational sessions, training, workshops, media coverage, and special events. Perceived effectiveness was primarily based on anecdotal feedback and assumptions that awareness, perceptions, attitudes, and knowledge of HIV had increased as a result of these activities among attendees and the general public. Some organizations and project sites assessed attitude changes and knowledge gains among attendees of specific presentations via pre- and post-program surveys and participant feedback forms (e.g., increased knowledge about HIV as a result of attending specific workshops and presentations).

In addition, several organizations worked to help people living with HIV access health and social services through providing individual level client advocacy and supporting them through the system (e.g., through attending medical appointments with clients and advocating on their behalf).

Several challenges remained with respect to creating supportive environments for people living with HIV. Operational site representatives reported ongoing stigma associated with HIV/AIDS and were continually striving to break down barriers and build acceptance through a variety of

mechanisms including relationship building, partnership development, public awareness campaigns, and other special events. In some cases, staff and volunteers reported personal experiences of being stigmatized or treated poorly as a result of their affiliation with the organization. Thus, while progress was being made, there was still a long way to go toward creating supportive environments for people living with HIV at the end of the 2001-2004 funding cycle.

Health Promotion for People Living with HIV

Among the operationally-funded organizations that provided direct service to people living with HIV, the importance of health promotion was emphasized, particularly in residential care settings. Organizations strived to increase the capacity of people living with HIV to manage their condition and to provide support for people affected by HIV through attending first to basic needs for food, shelter, health care and support.

It was noted that in many cases the capacity of people living with HIV had been enhanced to some extent through an increased recognition that PLWH are living longer (e.g., 20 years or more) and through shifting the emphasis of HIV as a terminal illness to a chronic condition.

Organizations also sought to involve people living with HIV directly in the delivery of programs and services wherever possible. People living with HIV were involved in operationally-funded organizations in a variety of ways including involvement as board members, volunteers, and staff; delivery of presentations; provision of peer support; completion of satisfaction surveys; participation in focus groups and workshops; and completion of individual goal planning and interviewing potential new residents (where applicable).

It was further observed, however, that working to help build the capacity of people living with HIV to lead healthy lives was a challenging process – and sometimes described as an uphill battle. Many people living with HIV were noted to also experience multiple circumstances such as mental health, poverty, homelessness, and addictions issues, making health promotion difficult. In particular, those considered unwilling or unable (U2) to prevent the spread of HIV posed a significant challenge to some operationally funded organizations.

Overall, the concept of health promotion for people living with HIV was valued if not always easy to implement given existing challenges and barriers. Key lessons learned about health promotion for people living with HIV focused on the complexity of issues and the importance of meeting basic needs.

Harm Reduction

Organizations worked to provide harm reduction activities to reduce the negative consequences of high risk behaviour in the community such as injection drug use, and to ensure the safety of individuals. Over one million needles were distributed annually across at least 8 central locations (with many additional satellite or traveling sites). Access to health and social services, referrals to other agencies, condom distribution, and support from staff were elements commonly integrated with needle distribution programs.

In some locations, methadone programs were also introduced during the three-year funding cycle. These programs were not funded by ACHF although several operationally-funded organizations contributed to lobbying for this service on behalf of their clients.

In addition, work with key stakeholders was undertaken to influence attitudes toward the harm reduction philosophy and approach.

Harm reduction programs, activities, and awareness building opportunities have been provided throughout the province. Are these activities making a difference? Feedback from operational site representatives suggests that attitudes are changing (toward increased acceptance of harm reduction) but that change has been slow and incremental. The trend toward decreased numbers of new HIV cases within the IDU population (based on the provincial infectious disease data report) could also be interpreted to suggest that the harm reduction activities were beginning to make an impact.

Prevention

Operational and project sites conducted a large volume of activities designed to prevent HIV in populations known to be vulnerable to HIV and a broad range of population groups were targeted. Activities were designed to increase awareness and knowledge regarding HIV and ultimately to encourage healthy lifestyle choices. The extent to which awareness, knowledge, and behaviour of target populations changed as a result of prevention programming was not always formally assessed. Changes were often inferred as a result of participating in a given program, presentation, workshop or other type of intervention. Exceptions included an increase in the use of workshop evaluation forms used to assess changes in participant knowledge and awareness. This practice was promising and there may be further opportunity to build on and enhance this type of data collection activity to better monitor the impact of prevention efforts in the future.

Strengthening Community Based Organizations

Funding was used in a variety of ways to help increase the skills and abilities of the people who work at all levels of the community-based HIV movement including board, staff, and volunteers.

A variety of training and development opportunities were provided including general orientation training, education sessions to increase knowledge regarding HIV, and additional training regarding a variety of specific topics including culture and diversity, research and evaluation, health and social services, peer support, volunteer recruitment, board development, fund development, harm reduction, facilitation, team building, crisis intervention, addictions and sexual health.

A common challenge reported by operationally-funded organizations, however, related to staff retention and recruitment. Staff turnover occurred within all operationally funded organizations throughout the three-year funding cycle.

Another common challenge emerged with respect to formal data collection and evaluation. However, progress was being made throughout the three-year funding cycle with increased attention to data collection activities such as workshop evaluations.

Partnerships also represented a significant component of efforts to strengthen community based organizations. A wide range of partners were engaged to help reduce pressure on organizational resources (long term) and to better meet the needs of client populations.

Recommendations

Seven recommendations were developed based on the evaluation findings. These recommendations, including supporting examples, are further described within the main body of this report. The overall categories of recommendations included the following:

- 1. Implement a recognition system for good or promising practices.**
- 2. Increase available support, training, and resources for evaluation.**
- 3. Further explore partnership assessment criteria.**
- 4. Improve mechanisms for information and resource sharing.**
- 5. Revisit the evaluation framework.**
- 6. Revisit project funding criteria.**
- 7. Create and implement a document review and management system.**

Concluding Comments

A great deal of activities intended to create supportive environments, facilitate health promotion for people living with HIV, prevent HIV among populations known to be vulnerable, reduce the negative consequences of high risk behaviour, and strengthen community based organizations were reported during the first three-year funding cycle. An evaluation framework was introduced part way through the funding cycle and organizations were encouraged to conduct routine data collection to help increase understanding regarding the impact of these activities. Progress, growth, areas for improvement, promising practices, and lessons learned were identified and have been summarized in this report to serve as a basis for reviewing, planning, and evaluating subsequent funding cycles.

1.0 Introduction and Methodology

1.1 Background

1.1.1 The Funding Approach to HIV in Alberta

The Alberta Community HIV Fund (ACHF) was implemented in 1999/2000 as a joint community, federal, and provincial initiative developed through consultation with representatives from community-based AIDS organizations, persons living with HIV, the regional health authorities, and provincial and federal health departments. Two categories of funding are available under the ACHF: operational funding and project funding. Operational funding supports the continuing local and provincial community-based response to the existing and emerging issues associated with HIV. Operational funding is available to fund programming, key positions within an organization, and overhead and administrative costs. Voluntary, non-profit, non-governmental organizations whose principal mandate is community-based HIV programming are eligible for funding. Project funding is available to fund time-limited (one year only), specific activities that address unmet needs and priorities relating to HIV. These activities may be local or provincial in scope. The ACHF is administered by the Alberta Community Council on HIV (ACCH), a partnership of fifteen non-profit, community-based HIV organizations.

1.1.2 Description of the Five Funding Approaches

Funding is classified according to one or more of the following five fund approaches:

- **Creating Supportive Environments:** To reduce social barriers that prevent people living with HIV, those at risk, and those affected, from accessing health care and social services.
- **Health Promotion for People Living with HIV/AIDS:** To increase the capacity of people living with HIV to manage their condition and support for people affected by HIV.
- **Prevention Initiatives:** To prevent HIV in populations known to be vulnerable to HIV.
- **Strengthening Community Based Organizations:** To increase the skills and abilities of the people who work at all levels of the community-based HIV movement: board, staff, and volunteers.
- **Harm Reduction:** To reduce the negative consequences of high risk behaviour in the community such as injection drug use, and to ensure the safety of individuals.

1.1.3 Provincial HIV Trends

Provincial surveillance data¹ show that the number of newly reported HIV cases in Alberta ranged from 134 to 189 cases per year between May 1998 and December 2004. The total number of newly reported cases during this time period was 1,182 (n=822, 70% male; n=360, 30% female). Among newly diagnosed males, the largest exposure categories were injection drug use (IDU) and men who have sex with men (MSM). There was a trend toward fewer IDU cases and more MSM cases in the last two years for which data was provided (2003-2004). Among newly diagnosed females, the largest exposure categories were IDU, heterosexual

¹ Source: Disease Control & Prevention Branch, Alberta Health and Wellness (presentation delivered to the ACHF Provincial Consortium, Ami Singh, Infectious Diseases Medical Consultant).

endemic countries, heterosexual partner at risk, and heterosexual no identified risk. There was a similar trend toward fewer IDU cases in the years 2003-2004, and an increase in heterosexual partner at risk (in 2003) and heterosexual endemic country (in 2004).

1.2 Purpose of the Evaluation

1.2.1 Development of the ACHF Evaluation Framework

In 2002, a comprehensive evaluation framework was designed to account for the collective results of HIV/AIDS work funded through the ACHF (see Appendix A). The framework was developed through a participatory process that included all organizations receiving operational funding through the ACHF. The evaluation framework includes eleven overall evaluation questions with corresponding indicators and data sources.

1.2.2 Purpose and Scope of the 2001-2004 Fund Cycle Evaluation

The purpose of the 2001-2004 fund cycle evaluation was to analyze and interpret data in relation to the evaluation questions outlined in the Alberta Community HIV Fund Provincial Evaluation Framework and to summarize data according to each of the five fund approaches.

The evaluation focused on the time frame April 2001 to March 2004 (i.e., the first 3-year funding cycle).

1.3 Evaluation Questions

The following eleven evaluation questions were included the evaluation framework:

- Have the organizational capacities of operationally funded organizations been enhanced through ACHF funding? [Question 1]
- To what extent have target population members been involved in program development, delivery and evaluation, and in the governance of operationally-funded organizations? [Question 2]
- To what extent is programming based on identified and projected community needs? [Question 3]
- How do partnerships impact our HIV/AIDS programming? [Question 4]
- To what extent have we contributed to HIV/AIDS issues being integrated into other organizations and sectors? [Question 5]
- How have we contributed to the public's awareness, perceptions/attitudes, knowledge of HIV? [Question 6]
- How have we contributed to enhancing the capacity of PLWH to lead safer and healthier lives? [Question 7]
- How have we impacted the quality of end of life care? [Question 8]
- How have we contributed to target populations' awareness, attitudes, knowledge, skills and access to resources (supports) that enable them to lead safer and healthier lives? [Question 9]

- What lessons have we learned about the effectiveness of our approaches? [Question 10]
- What are the identified best practices for each of the five ACHF approaches? [Question 11]

1.4 Data Collection and Analysis Methods

Data collection methods included a focused document review and key informant interviews. In addition, ongoing communication was conducted with ACCH and PHAC representatives as necessary to raise questions and clarify issues during the data collection and analysis phase.

1.4.1 Document Review

Narrative report summaries for operationally funded organizations and project sites were reviewed and coded according to each evaluation question and indicator (n=9 annual and bi-annual summary reports). Relevant data from individual narrative reports (n=90 operational site and 53 project site narrative reports) and accompanying materials were then extracted to fill specific gaps not answered by review of the narrative report summaries. Quantitative data were entered into an electronic spreadsheet for analyses. Qualitative data (e.g., descriptive examples) were entered into a word processing program for review by content and identification of thematic areas by evaluation question.

1.4.2 Key Informant Interviews

To supplement the document review process, telephone interviews with operational site representatives were conducted. One representative from each of the 15 partner organizations (not including the ACCH) was invited to participate in the evaluation. During the timeframe available for the interviews, 11 of 15 representatives agreed to participate. Detailed interview notes were maintained and summarized by interview question. Quantitative ratings were entered into an electronic spreadsheet for descriptive analyses. Qualitative feedback and comments were summarized and reviewed across question and participant to identify common and unique themes and response patterns.

Interview participants were asked to focus on the timeframe 2001-2004; however, several participants reported that it was difficult to recall whether changes had occurred during that timeframe or after. Other participants were not part of the organization during the first three year funding cycle and needed to rely on reports or briefings within the organization. However, for the most part, findings from the evaluation do not reflect changes or progress since March 2004.

1.5 Limitations and Strengths

1.5.1 Limitations

To reiterate, the evaluation findings are limited to the time period April 2001 – March 2004. They do not take into account changes or progress made since March 2004. Data sources were limited to the review of documents and key informant interviews. The scope of the evaluation focused primarily on ACHF funded initiatives and projects (i.e., excluding some HIV-related

work conducted under the auspices of other funding sources that may not have been documented in the narrative reports).

1.5.2 Strengths

The findings from the document review and interviews were relatively consistent (i.e., both sources of data revealed similar findings and trends). The interview data were particularly helpful for piecing together the “big picture” which was not always clear based on review of individual reports. In contrast, report data were helpful for monitoring progress over time given the realities of staff turnover and organizational change. Furthermore, discussions during the October 2005 Provincial Consortium meeting (Edmonton, Alberta) revealed consistencies in thematic areas and findings across several independent investigations².

1.6 Report Organization

The next section of this report includes an overview of the ACHF operationally funded organizations and project sites. Key findings are subsequently organized according to each of the five fund approaches and corresponding evaluation questions as outlined in Table 1.

Table 1. Evaluation Questions and Corresponding Fund Approach

Evaluation Question	Creating Supportive Environments	Health Promotion	Prevention	Strengthening Community Based Organizations	Harm Reduction
1. Have the organizational capacities of operationally funded organizations been enhanced through ACHF funding?				✓	
2. To what extent have target population members been involved in program development, delivery and evaluation, and in the governance of operationally-funded organizations?	✓	✓	✓	✓	✓
3. To what extent is programming based on identified and projected community needs?	✓	✓	✓	✓	✓
4. How do partnerships impact our HIV/AIDS programming?				✓	
5. To what extent have we contributed to HIV/AIDS issues being integrated into other organizations and sectors?	--	--	--	--	--
6. How have we contributed to the public's awareness, perceptions/attitudes, knowledge of HIV?	✓				
7. How have we contributed to enhancing the capacity of PLWH to lead safer and healthier lives?		✓			
8. How have we impacted the quality of end of life care?		✓			
9. How have we contributed to target populations' awareness, attitudes, knowledge, skills and access to resources (supports) that enable them to lead safer and healthier lives?			✓		✓
10. What lessons have we learned about the effectiveness of our approaches?	✓	✓	✓	✓	✓
11. What are the identified best practices for each of the five ACHF approaches?	✓	✓	✓	✓	✓

² Other investigations and findings described included: *The Alberta Community HIV Fund: An Independent Review and Evaluation of the Funding Model* (Broadview Applied Research Group, 2005) and *The Current and Future Environment of HIV/AIDS in Alberta: Environmental Scan* (ACCH, 2005).

2.0 Overview of ACHF Operational and Project Sites

Based on data provided in the annual and bi-annual summary reports, the Alberta Community HIV Fund allocated \$6,558,050.00 in operational and \$668,067.00 in project funding over the 3-year funding cycle. The total amount of annual funding (operational and harm reduction) for each organization is outlined in Table 2; project funding is outlined in Table 3. The primary target population across project sites is illustrated in Figure 1. [The target population(s) across operational sites was not classified in the same way as for project sites and is further explored in the Creating Supportive Environments section of this report.]

Table 2. Funding Allocations: Operationally Funded Organizations³

Organization	Year 1: April 2001 – March 2002		Year 2: April 2002 – March 2003		Year 3: April 2003 – March 2004		Total
	Operational	Harm Reduction	Operational	Harm Reduction	Operational	Harm Reduction	
1. AIDS Bow Valley	41,000.00	--	41,000.00	--	45,527.00	--	127,527.00
2. AIDS Calgary	363,510.00	--	363,510.00	--	402,118.00	--	1,129,138.00
3. HIV West Yellowhead	27,202.00	--	27,202.00	--	31,729.00	--	86,133.00
4. CAANS	113,116.00	30,000.00	113,116.00	35,000.00	127,787.00	30,000.00	449,019.00
5. HANSEAA	33,590.00	25,000.00	33,590.00	--	39,351.00	25,000.00	156,531.00
6. HIV Edmonton	299,494.00	--	299,494.00	--	334,061.00	--	933,049.00
7. HIV North	65,308.00	30,000.00	65,308.00	35,000.00	74,449.00	30,000.00	300,065.00
8. Kairos House	70,000.00	--	70,000.00	--	70,000.00	--	210,000.00
9. KAF	75,000.00	--	75,000.00	--	83,230.00	--	233,230.00
10. Lethbridge HIV Connection	85,325.00	25,000.00	85,325.00	30,000.00	97,670.00	25,000.00	348,320.00
11. Living Positive	59,385.00	--	59,385.00	--	65,969.00	--	184,739.00
12. Safeworks	--	224,220.00	--	229,220.00	--	242,674.00	696,114.00
13. SHARP Foundation	70,000.00	--	70,000.00	--	70,000.00	--	210,000.00
14. Streetworks	--	280,165.00	--	285,165.00	--	303,223.00	868,553.00
15. WBHAS	42,619.00	--	42,619.00	--	47,146.00	--	132,384.00
16. ACCH	158,128.00	--	164,416.00	--	164,416.00	--	486,960.00
17. ICARE	6,288.00	--	--	--	--	--	6,288.00
Annual Funding	1,509,965.00	614,385.00	1,509,965.00	614,385.00	1,653,453.00	655,897.00	\$6,558,050.00

Table 3. Funding Allocations – Time Limited Projects⁴

Project Site	Organization	Funding Amount
Year 1: April 2001 – March 2002		
1. Time for SECONDS (Supporting, Educating, and Collaborating on Diversity)	Barrhead & District Family & Community Support Services	19,420.00
2. HIV Peer Support Training Program	Canadian Red Cross	20,000.00
3. GLBT Community Development, Skills Building, and Gay Men's Outreach Project: Phase II	Gay and Lesbian Community Centre of Edmonton	19,950.00
4. Metis Education Testing Information Support	Metis Nation of Alberta	20,000.00

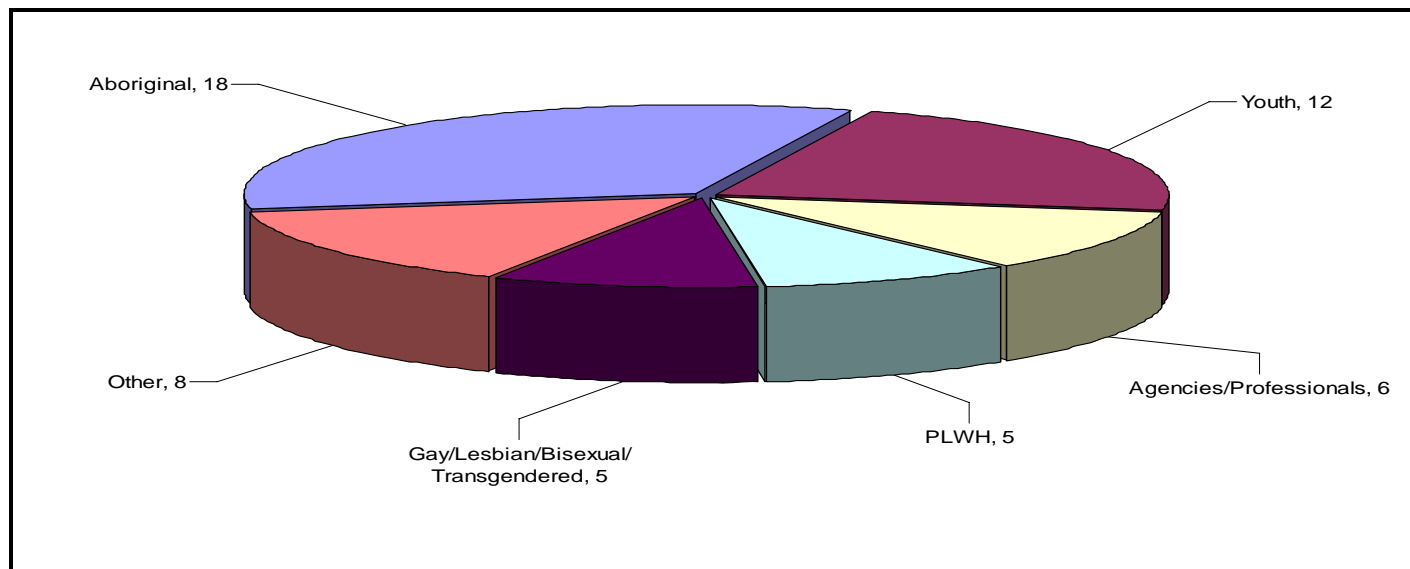
³ Note: An additional \$20,650.00 of project funding per year was noted in the operational sites annual summary reports. For the purpose of this summary, all project funding is reported separately in Table 3.

⁴ Note: The project summary table includes all dollars allocated; however, a few projects were not completed and funds were returned to the ACHF.

Project Site	Organization	Funding Amount
5. Workshop Delivery	Peace River Community AIDS Response and Education Society	19,420.00
6. Youth Supporting Youth	Planned Parenthood Alberta	20,000.00
7. Phase I: Developing Mentorship for At-Risk Adolescent Males	Planned Parenthood Association of Edmonton	16,902.00
8. Rocky AIDS Awareness Project	Rocky Native Friendship Centre	19,200.00
9. Healthy Choices and Lifestyles	Blue Heron Support Services Association	9,984.00
10. General Public Harm Reduction	The John Howard Society of Alberta	9,400.00
11. Continuing Education for Pharmacists in Harm Reduction	Boyle Street Co-op	10,600.00
12. Gay Men's Health Summit	Gay and Lesbian Community Services Association of Calgary	20,000.00
13. Urban Aboriginal Outreach Initiative and Awareness Campaign	Sik-oo-kotoki Friendship Society	1,200.00
14. Building Community Relations: HIV/AIDS Aboriginal Perspectives	Miywasin Society of Aboriginal Services	1,984.00
15. Raising Consciousness HIV Awareness for Aboriginal Youth	Metis Nation of Alberta	6,816.00
16. AIDS & HIV Awareness for Community Youth	New Horizon's Employment Assistance Service Centre (two projects)	4,000.00
17. Education will lead us past the blindness (HIV & STD conference)	Peace CARES	2,000.00
18. Wiya Wapaki Project	Alberta Native Friendship Centre	2,000.00
19. Two Spirits in Motion Project Phase I	Gay and Lesbian Community Centre of Edmonton	2,000.00
Year 1 project funding =		\$224,876.00
Year 2: April 2002 – March 2003		
1. HIV/AIDS Education in Healing Hands	Alberta Association of the Deaf	20,000.00
2. HIV Capacity Building Stream	Alberta Society for the Promotion of Sexual Health	6,045.00
3. Encouraging Changes in HIV Prevention Practices Through Social Marketing	Canadian Red Cross	20,000.00
4. Elizabeth Metis Settlements HIV/AIDS Project	HIV Edmonton	10,000.00
5. First Contact: Keeping Our Gay Youth HIV-Free	Gay & Lesbian Association of Lethbridge & Area	20,000.00
6. Two Spirits in Motion – Phase II	Gay and Lesbian Community Centre of Edmonton	20,000.00
7. Without Limits Holistic Outreach Program	Grande Prairie Friendship Centre	15,000.00
8. Aboriginal Youth HIV Awareness Project – Life Changes (project not completed)	High Prairie Native Friendship Centre	8,000.00
9. Youth Online Radio: A Voice for Youth	Planned Parenthood Alberta	20,000.00
10. Phase II: Developing Mentorship for At-Risk Adolescent Males	Planned Parenthood Edmonton	19,927.00
11. Community Needle Safety Project	Prostitution Awareness and Action Foundation of Edmonton	20,000.00
12. Southern Sudan Humanitarian and Cultural Association HIV/AIDS Initiative	Southern Sudan Humanitarian and Cultural Association	14,542.00
13. HIV Positive: Maximizing Quality of Life, Health and Safety	Alberta Community Council on HIV	9,038.00
14. Environmental Scan of Health and Social Supports for Rural and Urban Based Gay/Bisexual/Two Spirited MSM	Alberta Community Council on HIV	5,000.00
15. Spread the Knowledge, Not the Disease	Boys and Girls Club of Edmonton	1,500.00
16. Aboriginal Youth and HIV/AIDS: Who is responsible?	Services for Aboriginal Children and Youth	1,500.00
17. Ohci Oskiyayak: For the Youth	Alberta Native Friendship Centre	1,500.00
18. HIV/AIDS: It's Still Here	High Level Native Friendship Centre	6,000.00
19. Two Spirit Peoples: HIV/AIDS and Health	Nechi Training, Research & Health Promotions Institute	7,404.00
Year 2 project funding =		\$225,456.00
Year 3: April 2003 – March 2004		
1. Wiya Wapaki Cultural Resources Project	Alberta Native Friendship Centre	20,000.00

Project Site	Organization	Funding Amount
2. SAR Sexual Attitude Reassessment	Alberta Society for the Promotion of Sexual Health	7,500.00
3. The Way It Is (Video)	Bent Arrow Traditional Healing Society	16,000.00
4. HIV/AIDS and the Aboriginal Community – Training for Prevention	Canadian Red Cross Society Southern Alberta Region	13,900.00
5. The Tipi of Courage	Canadian Red Cross Society Southern Alberta Region	20,000.00
6. Reaching MSM: A Study of the Need for a Safer-Sex Outreach Project in Lethbridge	Gay and Lesbian Alliance of Lethbridge & Area	7,200.00
7. Building on Capacities – Supporting our Foster Parents & Foster Children (project not completed)	Metis Child and Family Services Society	20,000.00
8. Positive Action: Participatory Action Research Approach to Assessing the Relationship Skills Needs of At Risk Adolescent Females	Planned Parenthood Edmonton	20,000.00
9. Mobilizing Community Networks to Address the Housing and Treatment Needs of HIV Positive People Who are Unwilling or Unable to Prevent the Spread of HIV	Universal Rehabilitation Service Agency	20,000.00
10. Community of Helpers	Shining Mountains Living Community Services	20,000.00
11. Southern Sudan Humanitarian and Cultural Association Community Action on HIV/AIDS	Southern Sudan Humanitarian and Cultural Association	20,000.00
12. Peer Support Model Building Initiative	Canadian Red Cross Society Southern Alberta Region	18,000.00
13. Wabasca HIV Resource Allocation Initiative	Pee-Kis-Kwe-Tan Let's Talk Society	5,000.00
14. Gathering for Health on HIV/AIDS and Hep C	Services for Aboriginal Children and Youth	7,135.00
15. Community of Helpers	Life with Hepatitis Society	3,000.00
Year 3 project funding =		\$217,735.00
Total Project Funding (April 2001 – March 2004) =		\$668,067.00

Figure 1. Primary Target Population Across Project Sites⁵



⁵ Note: 9 of the 18 Aboriginal focused projects also included youth; thus there were 21 projects (12 + 9) in total with a youth focus. The “other” category included members of the general public, the Sudanese community, the rural community, foster parents, the deaf community, and adults with developmental disabilities.

3.0 Creating Supportive Environments

Creating Supportive Environments:

To reduce social barriers that prevent people living with HIV, those at risk, and those affected from accessing health care and social services.

Corresponding Evaluation Questions:

- To what extent have target population members been involved in program development, delivery and evaluation, and in the governance of operationally-funded organizations? [Evaluation Question #2]
- To what extent is programming based on identified and projected community needs? [Evaluation Question #3]
- How have we contributed to the public's awareness, perceptions, attitudes, and knowledge of HIV? [Evaluation Question #6]

3.1 Summary of Findings by Evaluation Question and Selected Indicators

To what extent have target population members been involved in program development, delivery and evaluation, and in the governance of operationally-funded organizations? [Evaluation Question #2]

Numbers of target population members involved in the organization [Indicator 2.1]

Operational Sites

The term “target population” was not always clearly defined, and the number of specific target population members involved in program development, delivery and evaluation, and the governance of operationally-funded organizations was not always stated. Thus, it was not possible to calculate the total number of target population members involved in operationally-funded organizations. However, most organizations reported efforts to increase target population member involvement.

Sometimes the target population referred to the general population in which case 100% of clients, staff, volunteers, and board members were classified as members of the target population. In other instances, target population referred to specific population groups such as people living with HIV; members of Aboriginal communities; young service industry workers; gay, lesbian, bisexual, and trans-gendered individuals; high risk men and women; injection drug users; sex trade workers; natural helpers; street-involved or otherwise at-risk youth; youth in schools; prison inmates; other service providers and health professionals; school boards; community partners; and others.

In some cases, numbers accompanied illustrative examples of the kinds of target population involvement. Examples of such numbers cited by organizations within each of the six-month reporting periods included: 9 presentations delivered by people living with HIV and/or HCV; 6 people living with HIV actively involved as board members; 6 youth involved in writing, developing, and performing a Fringe Festival play; 2 youth hired as peer health educators; 35 youth involved as special event volunteers; 55 participants provided informal feedback regarding programming; and 5 natural helpers developed an information booklet for injection drug users.

Although total numbers were not available, it was apparent that organizations had made a concerted effort to involve a broad range of target populations in a variety of capacities (e.g., as volunteers, staff, and board members).

Project Sites

Target population member involvement in operationally-funded organizations does not apply to project sites. In terms of target population involvement in the design and delivery of projects, for the most part, target population members were involved as recipients of project initiatives (e.g., through attending workshops, public presentations, skill building sessions, training, and/or participating in needs assessments and community based research). In some cases, target population members were directly involved in planning and delivering the project itself (such as the youth led Steering Committee responsible for creating and maintaining a youth oriented website).

Qualitative information on, and examples of, the extent of their involvement [Indicator 2.2]

Operational Sites (only)

A broad range of target population members were involved in operationally-funded organizations in a variety of ways including participation as board members, staff, and volunteers. Qualitative information on, and examples of, the extent of their involvement is further described in the “Prevention” fund approach section of this report.

To what extent is programming based on identified and projected community needs (e.g., blood borne pathogens, culture and diversity, multiple diagnoses)? How have the needs been identified and by whom? [Evaluation Question #3]

Note: This evaluation question corresponds with more than one fund approach. Some of the information pertaining to Evaluation Question 3 will be further addressed in later sections of this report (e.g., as it relates to Prevention and Health Promotion). The information presented in this section pertains to Creating Supportive Environments.

Needs assessment, evaluation, or community-based research informing programming; needs assessment could include surveys, focus groups, asset mapping, interviews, statistical health data review, ACCH meetings and workshop minutes regarding emerging issues, environmental scans, community stories, and anecdotal information [Indicator 3.1]

Operational Sites

A wide variety of needs assessments, evaluations, and community-based research projects were undertaken by operationally funded organizations to inform programming. The most commonly reported methods of identifying needs included interviews, surveys, focus groups, anecdotal information, and professional or personal experience. Needs assessments were conducted by a range of individuals including staff members of operationally funded organizations, volunteers, researchers, and consultants. In some cases, needs assessments or environmental scans were the primary focus of separate project funding.

The needs of specific population groups were explored including, for example, incarcerated people living with HIV, gay men, people living with HIV within residential care facilities, health professionals (information needs), and high risk youth.

It also appeared that a great deal of programming was based on some of the leading exposure categories for HIV as described in the statistical data summary reports including, for example, injection drug users, men who have sex with men, youth, and members of the Aboriginal community.

Several operational sites further identified a number of unmet needs within various population groups over the course of the three-year funding cycle. Some of these needs were subsequently met or were beginning to be addressed; others were noted as ongoing challenges.

Examples of unmet needs reported by operational sites included:

- the need for increased programming for and by Aboriginal people;
- the complex health care needs of women living with HIV;
- the need for increased contact, services, and information in rural communities regarding HIV and HCV;
- the complex and multiple needs of high risk populations (including needs for housing, employment, social support, and education);
- the need for methadone and detox programs in Central Alberta;
- the need for curriculum development regarding HIV/AIDS;
- financial needs of people living with HIV and the need for practical supports (e.g., transportation, treatment costs);
- the need for more information on harm reduction (among the general public as well as among health professionals and other service providers);
- the need for a safe and comfortable waiting area for client drop-ins;
- the need for developing better approaches to caring for clients “unwilling or unable” to prevent the spread of HIV (referred to as the U2 population);
- the need for more information and support for pregnant drug users;
- the need for programming and resources specific to HIV and tourism;
- the need for various services in one location (Health Village Model);
- the need for information about overdosing as a result of using other drugs while on methadone treatment ; and
- the need to develop more options in STI prevention for women.

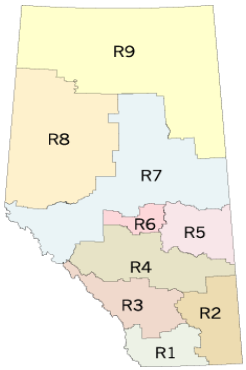
Project Sites

Time limited project funding was sometimes used to conduct needs assessments or to further explore issues that could not usually be addressed within the existing resource constraints of operationally funded organizations. For example, project funding was used to conduct an environmental scan of supports available for gay, bisexual and men who have sex with men in rural and urban Alberta; to assess the health promotion needs among people living with HIV; and to explore and develop a mentorship model that meets the needs of high risk young males.

Geographical coverage of operationally-funded organizations and project sites [Indicator 3.2]

Geographical coverage of operationally-funded organizations and project sites extended across most parts of the province with a higher concentration of organizations and projects within Calgary and Edmonton; see Table 4 for a depiction of geographic coverage by health region. Note that the health region geographic boundaries changed during the funding cycle from 17 to 9 health regions.

Table 4. Geographical Coverage by Health Region

	Health Region	# of Operationally Funded Organizations that Serve the Geographic Area ⁶	# of Projects that Served the Geographic Area ⁷
	1. Chinook	2	12
	2. Palliser	2	10
	3. Calgary	5	22
	4. David Thompson	2	11
	5. East Central	1	7
	6. Capital (Edmonton & Area)	5	21
	7. Aspen	2	11
	8. Peace Country	2	12
	9. Northern Lights	2	11

Demographics of reached populations [Indicator 3.3]

Operational Sites

Operational sites attempted to reach a broad group of population groups with diverse demographic characteristics. Specific programming was provided for and with people living with HIV (such as client drop-ins, counseling, peer and practical supports) as well as general prevention programming and public education. Targeted and/or reached populations included a variety of different age groups, cultures, socio-economic and employment status backgrounds. For example, youth programming addressed youth in schools, at-risk or urban street involved youth, young service industry workers, rural youth, Aboriginal youth, and others. Similarly,

⁶ Note: Some operationally funded organizations served more than one geographic area, and were counted in more than one health region. As a result, the total number of organizations by geographic location reported in Table 4 exceeds the total number of 15 operational sites.

⁷ Note: Similarly, some projects served more than one geographic area (e.g., workshops or training sessions delivered across several sites, or a conference targeting participants from multiple locations). Thus, the total number of projects by geographic location reported in Table 5 exceeds the total number of 53 projects.

programming (such as prevention messaging, public awareness campaigns, and harm reduction initiatives) was provided for a broad cross section adults – including the general public, men who have sex with men, low income and street-involved populations, health professionals and other service providers, Aboriginal communities, injection drug users, sex trade workers, and others.

Project Sites

The majority of projects were designed to reach one or more of the following population groups:

- Youth (including at-risk males, females, rural youth, and Aboriginal youth). More than one third of all projects (n=21; 39%) were intended to reach a segment of the youth population.
- Aboriginal communities (including Aboriginal youth, members of Aboriginal communities on and off reserve, two-spirit Aboriginals, and street-involved Aboriginal youth and adults). Approximately one third of all projects (n=18; 33%) were intended to reach a segment of the Aboriginal population. [Nine of these projects specifically targeted Aboriginal youth; these projects were classified under both categories: youth and Aboriginal focused projects.]
- Health professionals, agencies, and other service providers (including pharmacists and city staff members). The third most common target population (n=6; 11%) of time limited projects included health professionals, agencies and other service providers.
- Other groups: The remaining projects targeted a range of other groups including people living with HIV (n=5); gay/lesbian/bisexual/trans-gendered individuals (n=5); the Sudanese community (n=2); members of the general public (n=2); rural communities (n=1); foster parents (n=1, although project not completed); members of the deaf community (n=1); and adults with developmental disabilities (n=1).

How have we contributed to the public’s awareness, perceptions, attitudes, and knowledge of HIV? [Evaluation Question #6]

Public perception/attitudes, awareness, knowledge [Indicator 6.1]

Operational Sites

Operationally-funded organizations contributed to public awareness, perceptions, attitudes, and knowledge of HIV through an extremely high volume of reported activities such as public presentations, awareness campaigns, educational sessions, training, workshops, media coverage, and special events. Perceived effectiveness was primarily based on anecdotal feedback and assumptions that awareness, perceptions, attitudes, and knowledge of HIV had increased as a result of these activities among attendees and the general public. Some organizations and project sites assessed attitude changes and knowledge gains among attendees of specific presentations via pre- and post-program surveys and participant feedback forms (e.g., increased knowledge and acceptance of harm reduction was reported among pharmacists and health sciences students as a result of attending specific workshops and presentations).

Several challenges remained with respect to public perceptions, attitudes, awareness, and knowledge related to creating supportive environments for people living with HIV. Operational site representatives reported ongoing stigma associated with HIV/AIDS and were continually striving to break down barriers and build acceptance through a variety of mechanisms including relationship building, partnership development, public awareness campaigns, and other special

events. In some cases, staff and volunteers reported personal experiences of being stigmatized or treated poorly as a result of their affiliation with the organization.

Project Sites

The majority of time-limited projects involved presentations, workshops, and educational sessions designed to increase awareness and knowledge of HIV among the general public and within specific population groups (as previously described). Some projects also included the development of resources, manuals, and other tools to enhance public perceptions, attitudes, awareness, and knowledge. The impact of presentations and the utilization of resources was not always clearly specified, although some projects included pre- and post-assessments and participant feedback forms.

[Media coverage \[Indicator 6.2\]](#)

Operational Sites

Operationally funded organizations generated a great deal of media coverage including television spots, radio interviews, and newspaper articles. In addition, operational sites used a variety of mediums to communicate HIV messages such as videos, theatre performances, display booths, direct mail campaigns, word-of-mouth, public service announcements, pamphlets, posters, brochures, chalk murals, websites, newsletters, guest speakers, public presentations, resource booklets, coasters, trivia games, and other materials. One organization used a donated vehicle as the medium for communicating relevant contact information (Volkswagon Beetle) and reported that this resulted in increased community awareness regarding the organization.

Examples of various mediums and/or activities that often received local media coverage included health fairs, open houses (e.g., media open house), news releases, fundraisers and special events (e.g., AIDS walks, parades, music festivals and concerts, candlelight memorials, vigils, prayer flags), bar blitzes, sports and recreation events/tournaments (e.g., pool tournament; beach volleyball), and conference presentations.

Project Sites

Project sites used a variety of media sources to promote community events. For example, presentations, workshops, and other special events were advertised through local media sources (radio, newspaper, and television) to generate awareness and encourage attendance. The special events themselves often received local media coverage. In addition, project sites used a variety of mediums and created new resources to communicate HIV messages such as brochures, websites, posters, hats, display booths, newsletters, videos, and resource guides.

[Number of resources created and distributed \[Indicators 6.3 and 6.5\]](#)

Operational Sites

A wide variety of resources were created and distributed by operational sites. However, because precise numbers and descriptions were not always provided, it was not possible to determine exact totals or to differentiate between the number of resources created and the number distributed. Examples ranged from 5 to 10 to thousands of resources created and/or

distributed per six month reporting period. For example, operational sites often reported pamphlet distribution in excess of 1,500 pamphlets per six month period. The distribution of resources (such as pamphlets or booklets) often coincided with presentations, workshops, or other awareness campaign activities. Resources were estimated to reach populations ranging in size from 10 to 70,000 or more.

Project Sites

The development of specific resources was sometimes a key focus of time limited projects. Types of resources included brochures, websites, posters, display booths, newsletters, videos, resource guides, and training materials.

Number of public events (e.g., walks) [Indicator 6.4]

Operational Sites

Operational sites were involved in a large number of public events such as walks, fundraisers, and tournaments. However, it was not possible to calculate the total number of events because this information was not always reported for each site. At least several hundred events took place over the three-year funding cycle. During the document review process it was noted that one operational site used a very helpful format for tracking events, attendance, and other factors (such as weather conditions). This format may be useful for other sites to consider in tracking such events in the future.

Project Sites

Projects also contributed to the large volume of public events and awareness building activities. The majority of projects included some type of event or presentation targeted at either the general public or a specific sub-group such as the Aboriginal community, youth, health professionals, and others (as previously described). Types of events included educational presentations, health forum/summits, workshops, AIDS walks, and conferences.

Number of people reached through public education events and evaluation feedback [Indicator 6.6]

Operational Sites

A variety of people were reached through public education events including the general public (via community forums and health fairs) and specific population groups such as junior high, high school, and post-secondary students (during school-based presentations and workshops).

Examples of the total number of people reached per site ranged from 50 to 100 to several hundred or thousands depending on the nature of the public event. For example, health fairs were often reported to reach 1,500 to 2,500 participants at a time. School presentations were reported to reach thousands of participants as well in cases where presentations were delivered across school districts. However, attendance at events was not always specified; thus, it was not possible to calculate the total number of people reached.

Evaluation feedback from participants, when collected, generally demonstrated high levels of satisfaction. In some cases, feedback included suggestions for future education events (e.g., requests for more information about HCV).

Project Sites

A variety of people were reached through public events sponsored by project sites including members of the general public as well as specific population groups such as youth, adults, Aboriginal communities, health professionals, and others.

PLWH's perceptions of public acceptance of HIV and PLWH [Indicator 6.7]

Operational and Project Sites

The perceptions of people living with HIV regarding public acceptance of HIV and PLWH were not routinely assessed. Anecdotal information suggests that while much progress is being made in terms of increasing public acceptance, many challenges remain. People living with HIV often face multiple barriers such as stigma, low socio-economic status, and challenges accessing health care. It is inferred by the variety of activities underway to address these barriers, that progress is being made; however, it is also recognized that progress may be slow and that only incremental changes in public acceptance and understanding may be realized over time.

Summary Comments Regarding Creating Supportive Environments

A great deal of activity was undertaken by operational and project sites in an attempt to reduce social barriers that prevent people living with HIV, those at risk, and those affected from accessing health care and social services.

Misconceptions about HIV and negative public opinion are considered some of the barriers to accessing health care and social services, as well as lack of understanding among people living with HIV about what services are available and how to access them. Efforts were made to reduce misconceptions through education and awareness campaigns. In addition, operational sites made a broad range of contributions to increase the understanding among people living with HIV regarding available services and created ways to minimize barriers to access (such as the provision of special needs funds for people living with HIV and accompaniment to medical appointments).

Some of the most promising practices included the delivery of multiple health and social services in one location as well as outreach activities to bring the services to individuals where they are needed most.

Overall, progress was being made during the three year funding cycle with respect to creating supporting environments for people living with HIV, those at risk, and those affected. One of the most significant remaining barriers appeared to be related to stigma and discrimination, suggesting that much work remained to be done.

4.0 Health Promotion for People Living with HIV/AIDS

Health Promotion for People Living with HIV/AIDS⁸:

To increase the capacity of people living with HIV to manage their condition and support for people affected by HIV.

Corresponding Evaluation Questions:

- To what extent have target population members been involved in program development, delivery and evaluation, and in the governance of operationally-funded organizations? [Evaluation Question #2]
- To what extent is programming based on identified and projected community needs? [Evaluation Question #3]
- How have we contributed to enhancing the capacity of PLWH to lead safer and healthier lives? [Evaluation Question #7]
- How have we impacted the quality of end of life care? Quality of end of life care includes facilitation of a peaceful death, physical, mental, and spiritual support to client and loved ones. [Evaluation Question #8]

To what extent have target population members been involved in program development, delivery and evaluation, and in the governance of operationally-funded organizations? [Evaluation Question 2]

Numbers of target population members involved in the organization [Indicator 2.1]

Note: for the purpose of this section of the report, “target population” is defined as people living with HIV.

Operational Sites

As previously stated, “target population” was not always clearly defined and the number of target population members involved in the organization was not always stated. In some cases, the target population referred to specific population groups such as people living with HIV. However, it was not possible to calculate the total *number* of people living with HIV involved with operationally-funded organizations. There was evidence, however, of engagement of this target population in a variety of capacities (see Indicator 2.2). (When stated, numbers ranged from 7 to 350 people living with HIV involved with a given organization.)

⁸ Note: the evaluation framework category refers to People Living with HIV/AIDS. For consistent reporting purposes throughout this report the term people living with HIV or the acronym PLWH was used.

Project Sites

It was also not possible to calculate the total number of people living with HIV involved in the planning or delivery of time limited projects. Overall, very few projects (n=5) addressed health promotion for people living with HIV. Examples of projects that addressed this fund approach included peer support training and a needs assessment regarding the health promotion needs of people living with HIV.

Qualitative information on, and examples of, the extent of their involvement [Indicator 2.2]

Operational Sites

People living with HIV were involved in operationally-funded organizations in a variety of ways, including:

- Involvement as board members, volunteers, and staff;
- Delivery of presentations (e.g., junior high and high school classes; colleges and universities; conferences and other special events);
- Provision of peer support (or as participants in peer support training programs);
- Completion of satisfaction surveys;
- Participation in focus groups and workshops; and
- Completion of individual goal planning and interviewing potential new residents (where applicable).

Project Sites

Minimal involvement of people living with HIV was reported within time limited projects. Some exceptions were noted, including participation in peer support training and the provision of feedback regarding the health promotion needs of people living with HIV.

Key findings of the needs assessment included recognition of the inability of many PLWH to meet basic needs given the complexity of their lives. The assessment identified the need to shift focus from terminal illness to enhancing quality of life for people living with a chronic condition and concluded that “the ability of ASOs to deal effectively with HIV will depend on their willingness to tackle homophobia, sexism and racism, as well as issues relating to poverty, poor housing and inadequate health care.”

Evidence of increased engagement of the target population or of how their involvement has shaped programming [Indicator 2.3]

Operational Sites

Most operationally-funded organizations included direct involvement by people living with HIV on one or more than one level (e.g., staff, volunteer, board members, and clients). Target population involvement was encouraged and used to shape programming wherever possible. Direct participant feedback regarding specific programs or events was one of the most common forms of target population involvement used to shape programming. Feedback was sometimes collected formally through surveys or focus groups, or informally via individual comments and day-to-day interactions with target population groups.

Organizations that delivered direct day-to-day services to people living with HIV (e.g., residential care and support) tended to demonstrate very high levels of engagement through individual case planning and goal attainment monitoring/processes.

Project sites

It was anticipated that the results of the needs assessment for people living with HIV could be used to shape future programming (although it was not possible to assess the extent to which this has yet occurred).

To what extent is programming based on identified and projected community needs? [Evaluation Question 3]

Needs assessment, evaluation, or community-based research informing programming (needs assessment could include surveys, focus groups, asset mapping, interviews, statistical health data review, ACCH meetings and workshop minutes regarding emerging issues, environmental scans, community stories, and anecdotal information). [Indicator 3.1]

Operational Sites

As previously stated, a wide variety of needs assessments, evaluations, and community-based research projects were undertaken by operationally funded organizations to inform programming. The specific needs of people living with HIV (including sub-populations such as incarcerated people living with HIV) were often explored through these initiatives.

Several operational sites further identified a number of unmet needs within various population groups over the course of the three-year funding cycle. Some of these needs were subsequently met or were beginning to be addressed; others were noted as ongoing challenges. Examples of unmet needs specifically related to people living with HIV included the complex health care needs of women living with HIV; financial needs of people living with HIV and the need for practical supports (e.g., transportation, treatment costs); the need for a safe and comfortable waiting area for client drop-ins; the need for developing better approaches to caring for clients “unwilling or unable” to prevent the spread of HIV (referred to as the U2 population); and the need for various services in one location (which is beginning to be addressed in one setting through the introduction of the Health Village Model).

Project Sites

As stated under Indicator 2.3, it was anticipated that the results of the needs assessment for people living with HIV could be used to shape future programming (although it was not possible to assess the extent to which this has yet occurred). In addition, one project further addressed strategies for working with the unwilling or unable population. A comprehensive manual for working with this population was produced which may serve as a useful resource for other organizations as well.

Demographics of reached populations [Indicator 3.3]

Operational Sites

People living with HIV were broadly classified as a demographic of reached populations. Specific programming was provided for people living with HIV (such as client drop ins, counseling, peer and practical supports) as well as general prevention programming and public education messages. More detailed quantitative information regarding the demographics of people living with HIV, however, was not available. Anecdotal reports suggest that the client base of some organizations is predominantly comprised of Aboriginal males; however, a range of other demographic characteristics were reported including both males and females living with HIV. One organization reported recent progress (beyond the timeframe of the first three year funding cycle) with respect to maintaining a client demographic database to facilitate more detailed reporting in the future.

Project Sites

People living with HIV were not the primary “target audience” for the majority of time limited projects. Very few projects (n=5) addressed health promotion for people living with HIV. Some exceptions were noted, including participation by people living with HIV in peer support training and the provision of feedback regarding their health promotion needs.

How have we contributed to enhancing the capacity of PLWH to lead safer and healthier lives? [Evaluation Question 7]

PLWH have increased confidence in planning and achieving goals that are important to them [Indicator 7.1]

Operational Sites

Organizations engaged in direct service delivery to PLWH reported that some clients were able to plan and achieve goals that were important to them. In some cases, goal attainment was assessed via surveys and individual client level follow-up and communication.

Some operational site representatives reported that the capacity of PLWH to lead safer and healthier lives had been enhanced to some extent through an increased recognition that PLWH are living longer (e.g., 20 years or more) and through shifting the emphasis of HIV as a terminal illness to a chronic condition.

Organizations also cautioned, however, that people living with HIV often experience a range of other barriers that make it difficult to meet basic needs (such as needs for housing and social support). It was emphasized that achieving longer-term goals may be unrealistic for some people and that more supports are needed.

Project Sites

The confidence of PLWH in planning and achieving goals was not assessed within the time limited projects.

Peer and professional supports accessed [Indicator 7.2]

Operational Sites

It was not possible to calculate the total *number* of peer and professional supports accessed. However, people living with HIV accessed a wide *variety* of peer and professional supports through operationally funded organizations. For example, some people living with HIV accessed peer support groups and peer support training. Some organizations provided one-on-one counseling and referral services including assistance with other issues such as mental health, grief, housing, and poverty. Some organizations provided practical supports such as childcare assistance, transportation subsidies, nutritious meals, accompaniment to health appointments, provision of a stable environment and medications, assistance meeting basic needs for shelter and food, and individual client advocacy to reduce barriers to accessing services.

Project Sites

Some people living with HIV accessed peer support training through participation in the projects (e.g., two-weekend HIV Peer Support Training Program).

PLWH's knowledge of HIV management [Indicator 7.3]

Operational Sites

Given the observation that people living with HIV are living longer and healthier lives, it may be inferred that this corresponds in part with PLWH's knowledge of HIV management. For the most part, however, operationally funded organizations did not specifically measure changes in PLWH's knowledge of HIV management.

It was noted that while there may be general improvements in terms of knowledge of HIV management among some people living with HIV, many affected individuals experience a range of other barriers that make it difficult to meet basic needs (such as needs for housing and social support) and often require tremendous support in adhering to regular medication use, healthy nutrition choices, and other aspects of HIV management. For example, one organization reported that "...a stable environment that provides regular scheduled medication, good nutrition and education is vital in maintaining health...when residents deviate from the benefit of this stable environment, their health is immediately and directly affected". Another organization reported that "some clients have become more stable and continue with HIV treatment because staff have accompanied them to appointments."

Project Sites

People living with HIV's knowledge of HIV management was not addressed within the projects.

Attitude, awareness, knowledge, and self-esteem of PLWH [Indicator 7.4]

Operational Sites

In some cases, subtle changes in attitude, awareness, knowledge, and self-esteem of PLWH were reported by operational sites. For example, it was reported that many PLWH had obtained organizational and presentation skills as a result of participating in committees, workshops, and conferences. In many cases, delivering presentations and sharing ones life story was considered a very powerful experience both for the audience members as well as for the person living with HIV (e.g., increased self-esteem and sense of purpose).

Other reported changes (qualitatively) for some people living with HIV included increased knowledge about nutrition, improved nutrition choices, reduced drug use, increased independence, increased comfort with the diagnosis, reduced fears in disclosing HIV status, and improved social relationships including reconnecting with family and friends.

Project Sites

The attitude, awareness, knowledge, and self-esteem of PLWH was not addressed in the projects with the exception of feedback regarding their health promotion needs (as previously described).

PLWH make informed decisions/lifestyle choices to prevent HIV infection [Indicator 7.5]

Operational Sites

The extent to which PLWH made informed decisions and lifestyle choices to prevent the further spread of HIV was not explicitly assessed (with the exception of needle exchange rates); however, people living with HIV were provided with a variety of resources, information sources, and supports designed to *help them* make informed decisions and lifestyle choices. Their actual decisions and choices were not always measured; furthermore, it was often not possible to track the decisions made by transient clients.

Project Sites

The extent to which PLWH made informed decisions and lifestyle choices to prevent the further spread of HIV infection was not addressed within the time limited projects.

Needles and condoms distributed in the province annually, from # of locations [Indicator 7.6]

Operational Sites (only)

Needles: More than 4 million needles were distributed across the province through 8 operationally funded organizations during the first three year funding cycle. Some organizations distributed needles from multiple and/or mobile locations (via traveling van). More information regarding needle distribution is presented in the harm reduction section of this report.

Condoms: Condoms were frequently distributed during special events hosted by operational sites (e.g., bar blitzes and health fairs) although the total number of condoms distributed was

not always reported. In some cases, organizations distributed between 2,500 to 15,000 condoms in a given six-month reporting period. Based on review of the available data it is estimated that at least 600,000 condoms were distributed overall. This value is an estimate based on examples of numbers reported and may be much higher.

Number of referrals made to relevant supports (e.g., food, clothing, shelter, money, addiction, and health services) [Indicator 7.7]

Operational Sites

A variety of referrals were made to relevant supports; however, the total *number* of referrals made and client follow-up was not consistently reported across operational sites. In many cases, sites reported hundreds of referrals to a variety of other health and social support agencies within each six-month reporting period. Some sites maintained excellent records regarding type of referral and other factors; others were beginning to note that referrals were taking place.

Project Sites

Referrals to relevant supports for people living with HIV were not addressed through the projects.

PLWH have a sense of safety when accessing supports [Indicator 7.8]

Operational Sites

Some examples have already been provided which relate indirectly to PLWH's sense of safety when accessing supports. For example, some organizations offered accompaniment to clients for medical appointments and individual level client advocacy. These types of supports were reported to help increase comfort and sense of safety among some people living with HIV (e.g., reduced fear of disclosing HIV status); however, it is not known the extent to which this is generalizable to the majority of people living with HIV. Anecdotal evidence suggests that while progress is being made, there is still a long way to go in terms of increasing sense of safety when accessing supports. For example, some organizations reported that some people living with HIV prefer anonymous support and fear disclosing their HIV status (e.g., don't want employers or others to know).

Project Sites

PLWH's sense of safety when accessing supports was not addressed within the projects.

Satisfaction with specific services received and views on the benefits of the program (client, including loved ones', feedback) [Indicator 7.9]

Operational Sites (only)

Reported client satisfaction levels have been high. Excellent qualitative examples and testimonials from clients describing how programs have helped them were provided in several narrative reports. For example, clients from residential programs commented on a number of

positive aspects such as providing a stable environment, building trust, developing friendships, and finding a place where they could be themselves.

How have we impacted the quality of end of life care? [Evaluation Question #8]

Client, loved ones, and care team perceptions re: physical and mental health status of client and pain control/symptom management (including timely receipt of medication, anxiety management, and caregiver access). [Indicator 8.1]

Operational Sites (only)

Very few operational sites directly provided services to people living with HIV at the end-of-life stage. As a result, there were very few examples of reported client, loved ones, and care team perceptions regarding physical and mental health status, pain control and symptom management (including timely receipt of medication, anxiety management, and caregiver access) at the end-of-life. When provided, examples were generally positive, suggesting that clients and loved ones were satisfied with these elements of end-of-life care. In one specific example, the story of a person living with HIV was told to illustrate the extent to which the individual's specific requests at the end-of-life were honoured including the presence of a close family member. The powerful story is reproduced below as an example of quality end of life care.

"There were many players involved in his life to assist him in living his last days with dignity. His sister was there almost day and night, becoming a close member of our team. Home Care, the Doctor, the pharmacy and many home care workers added to the daily regime. This man was determined to die in the manner in which he chose. A couple of weeks before he passed away we talked about what he wanted. He stated 'I want to be in my bed, with my dog (a birthday present) and my sister'. He also indicated that he would like one certain staff with him. The staff he wanted to be with took a few vacation days. Prior to her return the resident asked other staff when she would be back at work. They told him she would be returning in two days (Sunday). She returned to work on Sunday morning at 6:30 and by 2:30 he passed away. He had his sister lying beside him, he was holding his dog, and the staff was there.... This story exemplifies one of the many opportunities that are given to provide for the people that live at the house, to have a person's last wishes honoured and shared with people that care."

Some organizations further noted the complexity and time required for quality end-of-life care. In some cases this service was beyond their capacity and staff began to teach family members about palliative care to help share the responsibilities.

Number of AIDS related deaths observed and client and loved ones satisfaction with services received, including loved ones' access to services after death of client [Indicator 8.2]

Operational Sites (only)

Very few AIDS related deaths were described overall, with the exception of one six month reporting period for one organization when several deaths resulted in a significant impact on staff and residents due to sheer number at one time. Again, it was noted that people are living longer and are not necessarily dying of AIDS but of other complications (e.g., addictions related), underscoring the importance of health promotion for people living with HIV.

Where applicable, organizations reported positive feedback from residents, their loved ones, physicians, social workers, and palliative care specialists regarding end-of-life care.

Summary Comments Regarding Health Promotion for People Living With HIV

Among the operationally-funded organizations that provided direct service to people living with HIV, the importance of health promotion was emphasized, particularly in residential care settings. Organizations strived to increase the capacity of people living with HIV to manage their condition and to provide support for people affected by HIV through attending first to basic needs for food, shelter, health care and support.

It was noted that in many cases the capacity of people living with HIV had been enhanced to some extent through an increased recognition that PLWH are living longer (e.g., 20 years or more) and through shifting the emphasis of HIV as a terminal illness to a chronic condition.

Organizations also sought to involve people living with HIV directly in the delivery of programs and services wherever possible. People living with HIV were involved in operationally-funded organizations in a variety of ways including involvement as board members, volunteers, and staff; delivery of presentations; provision of peer support; completion of satisfaction surveys; participation in focus groups and workshops; and completion of individual goal planning and interviewing potential new residents (where applicable).

It was further observed, however, that working to help build the capacity of people living with HIV to lead healthy lives was a challenging process – and sometimes described as an uphill battle. Many people living with HIV were noted to also experience multiple circumstances such as mental health, poverty, homelessness, and addictions issues, making health promotion difficult. In particular, those considered unwilling or unable (U2) to prevent the spread of HIV posed a significant challenge to some operationally funded organizations.

Overall, the concept of health promotion for people living with HIV was valued if not always easy to implement given existing challenges and barriers. Key lessons learned about health promotion for people living with HIV focused on the complexity of issues and the importance of meeting basic needs.

5.0 Prevention Initiatives

Prevention Initiatives:

To prevent HIV in populations known to be vulnerable to HIV.

Corresponding Evaluation Questions:

- To what extent have target population members been involved in program development, delivery and evaluation, and in the governance of operationally-funded organizations? [Evaluation Question #2]
- To what extent is programming based on identified and projected community needs? [Evaluation Question #3]
- How have we contributed to target populations' awareness, attitudes, knowledge, skills and access to resources (supports) that enable them to lead safer and healthier lives? [Evaluation Question #9]

To what extent have target population members been involved in program development, delivery and evaluation, and in the governance of operationally-funded organizations? [Evaluation Question #2]

Numbers of target population members involved in the organization [Indicator 2.1]

Operational Sites

As previously stated, the term "target population" was not always clearly defined, and the number of specific target population members involved in program development, delivery and evaluation, and the governance of operationally-funded organizations was not always stated. Thus, it was not possible to calculate the total number of target population members involved in operationally-funded organizations. However, most organizations reported efforts to increase target population member involvement.

Sometimes the target population referred to the general population in which case 100% of clients, staff, volunteers, and board members were classified as members of the target population. In other instances, target population referred to specific population groups such as people living with HIV; members of Aboriginal communities; young service industry workers; gay, lesbian, bisexual, and trans-gendered individuals; high risk men and women; injection drug users; sex trade workers; natural helpers; street-involved or otherwise at-risk youth; youth in schools; prison inmates; other service providers and health professionals; school boards; community partners; and others.

In some cases, numbers accompanied illustrative examples of the kinds of target population involvement. Examples of such numbers cited by organizations within each of the six-month reporting periods included: 9 presentations delivered by people living with HIV and/or HCV; 6 people living with HIV actively involved as board members; 6 youth involved in writing,

developing, and performing a Fringe Festival play; 2 youth hired as peer health educators; 35 youth involved as special event volunteers; 55 participants provided informal feedback regarding programming; and 5 natural helpers developed an information booklet for injection drug users.

Although total numbers were not available, it was apparent that organizations had made a concerted effort to involve a broad range of target populations in a variety of capacities (e.g., as volunteers, staff, and board members).

Project Sites

Target population member involvement in operationally-funded organizations does not apply to project sites. In terms of target population involvement in the design and delivery of projects, for the most part, target population members were involved as recipients of project initiatives (e.g., through attending workshops, public presentations, skill building sessions, training, and/or participating in needs assessments and community based research). In some cases, target population members were directly involved in planning and delivering the project itself (such as the youth led Steering Committee responsible for creating and maintaining a youth oriented website).

Qualitative information on, and examples of, the extent of their involvement [Indicator 2.2]

Operational Sites (only)

A broad range of target population members were involved in operationally-funded organizations in a variety of ways to address the prevention of HIV. Examples of target population involvement is outlined in Table 6.

Table 5. Examples of Target Population Involvement in Operationally-Funded Organizations

Target Population ⁹	Qualitative information on, and examples of, the extent of their involvement ¹⁰
People living with HIV	<ul style="list-style-type: none"> ▪ Involved as board members, volunteers, and staff ▪ Delivered presentations (e.g., junior high and high school classes; colleges and universities; conferences and other special events) ▪ Provided and/or undertook training related to peer support ▪ Completed satisfaction surveys ▪ Participated in focus groups and workshops ▪ In some cases (where applicable) completed individual goal planning and helped to interview potential new residents
Members of Aboriginal communities	<ul style="list-style-type: none"> ▪ Participated on planning committees and working groups ▪ Delivered presentations ▪ Organized and delivered a conference ▪ Provided and/or undertook training in peer education

⁹ Note: This is not an exhaustive list of target populations, but rather a selected list based on those populations more frequently identified and for whom examples of involvement in organizations were provided.

¹⁰ Note: This is not an exhaustive list of types of involvement, but is an overview of the more common types of involvement described for each target population.

Target Population ⁹	Qualitative information on, and examples of, the extent of their involvement ¹⁰
Young service industry workers	<ul style="list-style-type: none"> ▪ Participated in pub nights and special events
Youth (including street-involved or otherwise at-risk youth)	<ul style="list-style-type: none"> ▪ Wrote and delivered a Fringe Festival play ▪ Formed a Youth Steering Committee ▪ Created and maintained a website, internet radio show, chat room and online peer support ▪ Created newsletters and magazines (e.g., street magazine “Naked” addressing issues around sexuality, HIV prevention, drug use, relationships, and self-esteem) ▪ Participated on Provincial Youth Committee on HIV/AIDS issues
Injection Drug Users	<ul style="list-style-type: none"> ▪ Participated, when possible, in needle clean-up and disposal activities (e.g., weekly walks around needle distribution sites) ▪ Provided feedback regarding programming ▪ Note: difficulties engaging injection drug users in the governance of operationally funded organizations were reported given boundary issues and the chaotic nature of clients’ lives.
Sex trade workers	<ul style="list-style-type: none"> ▪ Contributed to the development of resource materials
Gay, lesbian, bisexual, and trans-gendered individuals	<ul style="list-style-type: none"> ▪ Provided feedback regarding programming ▪ Participated in projects, workshops, and conferences
Natural helpers ¹¹	<ul style="list-style-type: none"> ▪ Developed of information booklet for injection drug users; ▪ Spoke publicly on issues affecting them and their peers; ▪ Formed an advisory committee and were directly involved in planning for the Alberta Harm Reduction Conference
Health professionals, other service providers, community representatives and partners	<ul style="list-style-type: none"> ▪ Participated on working groups and planning committees

Evidence of increased engagement of the target population or of how their involvement has shaped programming [Indicator 2.3]

Operational Sites (only)

Evidence of increased engagement of various target populations, or of how their involvement has shaped prevention programming, emerged predominantly through anecdotal evidence and participant feedback forms following special events. It was not possible to quantify the overall level of engagement of the target population given the previously described challenges (i.e., numbers not consistently reported; target population not always defined). It is not clear whether the overall *number* of target population members involved in operationally funded organizations increased or decreased over the funding cycle. However, several qualitative observations were made with respect to the *type* and *nature* of target population involvement over the three year funding cycle.

¹¹ Definition of natural helpers: “We know that lots of people who are street involved don’t always use everyday services but are really good at looking after each other. Natural Helpers is a name we give to people from the community who teach and help others. They play a big part in helping the people around them make healthier and safer decisions in their life.” [Source: www.streetworks.ca]

Many organizations reported that target population involvement was encouraged and used to shape programming wherever possible. Direct participant feedback regarding specific programs or events was one of the most common forms of target population involvement used to shape programming. Feedback was sometimes collected formally through surveys or focus groups, or informally via individual comments and day-to-day interactions with target population groups.

Several organizations reported success with events that are fun and easily accessible and that provide direct access to condoms and information where it's most needed without youth having to seek it out. A common approach was to bring services and events to where people already gather such as bars, clubs, and concerts. Other lessons learned included the value of non-stigma advertising (e.g., labeling prevention oriented events with language other than AIDS or HIV, such as the Hot Times volleyball tournament or Real Life Projects).

Some organizations reported that the greater the involvement of specific target populations (e.g., the more involved with program creation, implementation, and evaluation) the more ownership they take of the program, the more pride they feel in their role in it, and the more successful the program can become. A few examples where target population involvement was considered critical included the delivery of youth presentations, engagement of Aboriginal communities, and the development of resources for street-involved and IDU populations (including street-involved pregnant women).

To what extent is programming based on identified and projected community needs? [Evaluation Question 3]

Needs assessment, evaluation, or community-based research informing programming (needs assessment could include surveys, focus groups, asset mapping, interviews, statistical health data review, ACCH meetings and workshop minutes regarding emerging issues, environmental scans, community stories, and anecdotal information). [Indicator 3.1]

Operational Sites

As previously stated, a wide variety of needs assessments, evaluations, and community-based research projects were undertaken by operationally funded organizations to inform programming. The information summarized in this section of this report refers specifically to activities that relate to the "Prevention" fund approach.

In terms of preventing HIV in populations at-risk or otherwise known to be vulnerable, it appeared that a great deal of programming was based on some of the leading exposure categories for HIV as described in the statistical data summary reports presented by Alberta Health and Wellness. Programming was targeted at a range of population groups including, for example, injection drug users, men who have sex with men, youth, and members of the Aboriginal community.

Project Sites

As previously stated, time limited project funding was sometimes used to conduct needs assessments or to further explore issues that could not usually be addressed within the existing resource constraints of operationally funded organizations. The majority of projects addressed the "Prevention" fund approach.

Demographics of reached populations [Indicator 3.3]

Operational Sites

The demographics of reached populations as reported by operational sites were diverse. Targeted and/or reached populations included a variety of different age groups, cultures, socio-economic and employment status backgrounds. It is not possible to graphically depict numbers reached because of the variability in reporting and lack of a total overall number.

Project Sites

Prevention projects were delivered to a range of target populations including, for example, youth, Aboriginal communities, health professionals, people living with HIV, gay/lesbian/bisexual/trans-gendered individuals, and the general public. The majority of projects emphasized prevention for youth and/or Aboriginal communities.

How have we contributed to target populations' awareness, attitudes, knowledge, skills and access to resources (supports) that enable them to lead safer and healthier lives? [Evaluation Question 9]

Number and types of outreach activities [Indicator 9.1]¹²

Operational Sites

Operational sites emphasized prevention through a variety of outreach activities such as connecting with youth in convenient and accessible locations (e.g., bar blitzes, concerts, and festivals) and by distributing prevention-related materials such as condoms and resource booklets for more information. A high volume of these types of activities were reported. For example, some operational sites delivered 50 to 75 HIV prevention presentations within a given six month reporting period. Outreach with street involved populations was also conducted by several operational sites. In some cases, operational sites reported reaching hundreds of street involved individuals within a given reporting period (e.g., 840 youth via street outreach conducted by agency staff).

Project Sites

The majority of projects addressed prevention through awareness campaigns, resources and training developed for the general population as well as specific target groups. Project workshops were hosted across the province in an attempt to reach southern, northern, rural and urban populations. Some projects hosted presentations and workshops across a variety of locations (e.g., 10 or more schools and community events within one project).

Peer and professional supports accessed (contacts with target populations, intensity and quality) [Indicator 9.2]

¹² Note: Indicator 9.1 also overlaps with indicators 1.4 and 6.4.

Operational Sites (only)

In addition to the peer and professional supports provided to people living with HIV (previously described under the health promotion for people living with HIV fund approach), a number of peer and professional supports were also provided to other specific target populations. For example, organizations provide outreach and support for street involved populations, injection drug users, youth, men who have sex with men, females, and several other specific groups.

Attitudes, awareness, knowledge, and self-esteem of support group participants [Indicator 9.3]

Operational Sites (only)

The attitudes, awareness, knowledge and self-esteem of support group participants were not consistently reported. Anecdotal feedback suggests that participants tended to be satisfied with the support available, although the impact of the support group was not always formally assessed. Positive benefits of participating in support groups were reported including, for example, increased social support and increased knowledge and awareness. Benefits tended to be reported by staff on behalf of clients based on perceptions and informal observations.

Pre and post attitude, awareness, knowledge scores of target population members via reached programming Indicator 9.4

Operational Sites

Reported changes in attitudes, awareness, and knowledge of target population members were often based on assumptions and anecdotal information (i.e., based on an expectation that the activities would contribute to target population attitudes, awareness, and knowledge). However, an increase in surveys, focus groups, and interview methods used to collect feedback from target populations was observed over the three-year funding cycle. In particular, a trend toward increased use of pre and post workshop/presentation evaluation forms to assess awareness and knowledge changes was observed.

Project Sites

Very little information regarding pre and post attitude, awareness, and knowledge scores of target population members was reported in the project site reports. It was usually inferred anecdotally that participants had increased awareness about HIV through participation in workshops or attendance at presentations. One project, however, collected information from youth regarding future intentions (as an indicator of future behaviour) and reported that many of the participating youth intended to make healthy lifestyle choices as a result of what they had learned through the project.

Reached target population members make informed decisions/lifestyle choices to prevent HIV infection [Indicator 9.5]

Operational Sites

Information regarding the decisions and lifestyle choices of reached target population members was not regularly provided nor formally assessed. It was often inferred and hoped that reached

population members would make informed decisions as a result of participation in the various prevention-oriented activities.

Project Sites

Similarly, information regarding the decisions and lifestyle choices of reached target population members was not regularly provided nor formally assessed within the time limited projects. This observation (relative lack of behaviour/outcome data) was even more pronounced in the project reports given the shorter time frame for project implementation, reporting and evaluation.

Number of needles and condoms distributed in the province [Indicator 9.6]

Operational Sites

Condoms were frequently distributed during special events hosted by operational sites (e.g., bar blitzes and health fairs) although the total number of condoms distributed was not always reported. In some cases, organizations distributed between 2,500 to 15,000 condoms in a given six-month reporting period. Based on review of the available data it is estimated that at least 600,000 condoms were distributed overall. This value is an estimate based on examples of numbers reported and may be much higher.

Project Sites

In some cases, the distribution of condoms was referred to in project reports but numbers were not always consistently reported.

Number and types of educational opportunities, resources, visitors to websites, media coverage, and populations targeted by resources [Indicator 9.7]

Operational Sites

Again, a broad range of educational opportunities and resources were provided by operational sites. Activities generated a tremendous volume of media coverage and sought to reach a wide variety of target populations. The precise number of such opportunities is not known but at a minimum the number of opportunities exceeds thousands (based on examples provided in the narrative reports).

Project Sites

Similarly, many projects focused on the delivery of education opportunities (such as presentations, workshops, conferences, etc.) and/or the creation and distribution of resources. There were at least 50 such opportunities provided throughout the projects.

Number of people getting tested for HIV and accessing pre and post-test counseling [Indicator 9.8]

The number of people getting tested for HIV and accessing pre and post-test counseling was not always stated¹³. However, when this type of data was reported it tended to be comprehensive and based on individual client-level service utilization statistics. However, given the lack of data, it is not possible to report the *total number* of people getting tested. Sites that provided HIV testing statistics reported very few positive tests.

Number of referrals made to relevant supports (e.g., food, clothing, shelter, money, addiction, and health services [Indicator 9.9]

This section includes information regarding referrals made to relevant supports as it relates specifically to the prevention of HIV (versus referrals made to supports for people living with HIV as described in the “Health Promotion” fund approach section of this report).

Organizations reported a large volume of referrals to relevant supports for at-risk populations (e.g., referrals to health care services and other supports for street-involved individuals). Some organizations maintained detailed statistics regarding the type and number of referral but overall reporting regarding the number, type, and outcome of referrals was not routinely completed.

Partnerships with the agencies where referrals were made were considered extremely important. This issue is further explored within the “Strengthening Community Based Organizations” fund approach section of this report.

Summary Comments Regarding Prevention

Operational and project sites conducted a large volume of activities designed to prevent HIV in populations known to be vulnerable to HIV and a broad range of population groups were targeted. Activities were designed to increase awareness and knowledge regarding HIV and ultimately to encourage healthy lifestyle choices. The extent to which awareness, knowledge, and behaviour of target populations changed as a result of prevention programming was not always formally assessed. Changes were often inferred as a result of participating in a given program, presentation, workshop or other type of intervention. Exceptions included an increase in the use of workshop evaluation forms used to assess changes in participant knowledge and awareness. This practice was promising and there may be further opportunity to build on and enhance this type of data collection activity to better monitor the impact of prevention efforts in the future.

¹³ Statistics regarding number of HIV tests across the province may be sought from provincial health utilization records.

6.0 Strengthening Community Based Organizations

Strengthening Community Based Organizations: To increase the skills and abilities of the people who work at all levels of the community-based HIV movement: board, staff, and volunteers.

Corresponding Evaluation Questions:

- Have the organizational capacities of operationally funded organizations been enhanced through ACHF funding? If so, how? [Evaluation Question #1]
- To what extent have target population members been involved in program development, delivery and evaluation, and in the governance of operationally-funded organizations? [Evaluation Question #2]
- To what extent is programming based on identified and projected community needs? [Evaluation Question #3]
- How do partnerships impact our HIV/AIDS programming? (Impact: contribute to effectiveness and sustainability) [Evaluation Question #4]

Note: the information presented with respect to this fund approach pertains only to operationally-funded organizations.

Have the organizational capacities of operationally funded organizations been enhanced through ACHF funding? If so, how? Core organizational capacities include human resource management, financial resource management, service delivery, external relations, organizational learning, and strategic management. [Evaluation Question #1]

Staff and volunteers recruited and kept (ideally over two years). [Indicator 1.1]

Operational Sites (only)

Staff

Staff turnover occurred within all operationally funded organizations throughout the three-year funding cycle and was frequently noted as a challenge in the narrative reports as well as during key informant interviews. While the challenges associated with staff recruitment and retention in non-profit organizations are not unique to HIV/AIDS service organizations, this issue represented a very real concern for operationally funded organizations.

Illustrative comments included:

“The new benefit package [for] employees and the many training opportunities were not sufficient to keep the program coordinator hired a year ago. Agencies like ours remain a training ground for young professionals, and it can be expected that they will move on to better paying jobs after awhile....”
(narrative report)

“The work has grown and grown and grown. It is an exhaustive burden on staff.” (interview)

“This work is very hard on staff. The staff I went through in that three-year period!! For some people, this is not the work for them. Poor pay is a factor. I have cut positions to give people raises. It’s emotionally difficult. Stigma and discrimination affects staff, too.” (interview)

Reported challenges to staff recruitment and retention included low salaries, high job expectations and pressure, stigma, complex client populations, and emotionally charged work.

The number of reported staff members ranged from 1 to 19 per organization. The average number across the three year funding cycle was 6 staff per organization. However, several challenges were encountered with respect to reporting and interpretation. For example, the number of staff per organization was not recorded in the first funding year. Thus, numbers are based only on reporting from April 2002 – March 2004 (four reporting periods). In subsequent years, several inconsistencies were observed with respect to the data reporting format. For example, it was not always clear how many staff were full time, part-time, contract, casual, or funded through sources other than the ACHF. In the last two reporting periods, a reduction in the reported number of staff was observed, although this was accompanied by a corresponding increase in explanations regarding the number of staff directly funded by ACHF and those funded by other sources. In addition, some concern was expressed that funding might be at risk if organizations were perceived to have sufficient staff. Several organizations further emphasized that there is always a need for more funding and more staff.

Most organizations (n=10) reported a decrease in the number of staff over the three year funding cycle. Three reported the same number of staff and the remaining two organizations reported an increased number of staff. Overall, the number of reported staff decreases ranged from 1 to 9 fewer staff members per organization over the three-year funding cycle. Again, these numbers should be interpreted with caution because the extent to which changes in reporting formats impacted these values is not clear.

Volunteers

Operationally funded organizations depended to a large extent on volunteer participation. All organizations reported some level of volunteer involvement. The definition of “volunteer”, however, was not always clear. Volunteer activity ranged from one-time participation in special events (e.g., AIDS walk volunteers) to ongoing, regular participation in an organization.

The average number of volunteers at each organization ranged from 12 to 226 (i.e., the average number across three years). Two organizations reported significantly more volunteers than the

others (e.g., 100 volunteers participated in the AIDS walk). A slight increase in the total number of volunteers across all 15 organizations was observed (from 577 to 778 at the end of the three year funding cycle).

Some organizations reported difficulty recruiting new volunteers as a result of a limited volunteer base, transient populations, and community stigma regarding HIV. Other organizations reported an extremely high reliance on volunteers and expressed concern regarding volunteer burnout (e.g., “Our volunteers are stretched”).

Board Members

The total number of board members ranged from 6 to 13 per organization. This number is based on information from 12 of 15 operationally-funded organizations. The remaining three either did not have a board or did not consistently report the number of board members. Board turnover was also a reality among many organizations during the three year funding cycle.

Training initiatives to support staff, volunteer and board member retention are described next.

[Staff, board, volunteer, client, and student training \(topics, evaluation results, knowledge and skills acquired, # trained\). \[Indicator 1.2\]](#)

A wide variety of staff, board, volunteer, client, and student training was reported within operational sites. Training categories and examples of training are outlined in Table 6.

Table 6. Organizational Training Opportunities

Category	Examples of Training or Resources Provided
Agency orientation/general staff, volunteer, and board member training	<ul style="list-style-type: none"> ▪ Orientation/training about the agency ▪ Provision of personnel policy manual ▪ Provision of organizational policy manual
HIV Knowledge/Awareness/Attitudes	<ul style="list-style-type: none"> ▪ Safer Sex and HIV ▪ Changing/Emerging HIV issues ▪ Living with HIV/AIDS ▪ HIV/AIDS 101 ▪ Alberta Positive Network Symposium ▪ Challenging stereotypes ▪ Presentations from PLWH ▪ Universal precautions ▪ Dynamics of HIV
Culture and Diversity	<ul style="list-style-type: none"> ▪ Talking Circle/Cultural Sensitivity/Diversity Training ▪ Aboriginal Awareness
Research and Evaluation	<ul style="list-style-type: none"> ▪ Community Based Research (workshop) ▪ ACCH Skills Building
Health and Social Services	<ul style="list-style-type: none"> ▪ In-services for nurses (re: vaccines) ▪ Accredited session for pharmacists ▪ Medication Delivery ▪ Education sessions on other agencies ▪ Pharmaceutical HIV medications training ▪ Mental health

Category	Examples of Training or Resources Provided
	<ul style="list-style-type: none"> ▪ Workshop with RHA regarding services for PLWH ▪ First aid and CPR
Peer Support	<ul style="list-style-type: none"> ▪ Train the trainer workshop to help start HIV Peer Support Group ▪ Peer counselor training
Volunteer Recruitment	<ul style="list-style-type: none"> ▪ Volunteer recruitment training/courses ▪ Volunteer coordinator training courses ▪ Volunteer recruitment brochures/posters ▪ Formal volunteer program developed and implemented (including policies and procedures for screening, placement, orientation, training, marketing, recruitment, and retention of volunteers)
Board Development	<ul style="list-style-type: none"> ▪ Board development workshop ▪ Provision of board recruitment package, governance manual, executive limitations, board-staff relationship manual, revised bylaws ▪ Board orientation package ▪ Board retreats
Fund Development	<ul style="list-style-type: none"> ▪ One agency engaged a fund development mentor for a 15 month period to assess and develop organizational capacity related to fund development, communications, and marketing strategies.
Harm Reduction	<ul style="list-style-type: none"> ▪ Harm reduction course (local) and National & Alberta Harm Reduction conference ▪ Consultation with experts in community to help inform staff of best practices in harm reduction
Facilitation/team building/crisis intervention	<ul style="list-style-type: none"> ▪ Facilitator Training course ▪ Team development ▪ Non-Violent Crisis Intervention ▪ Train the trainer programs ▪ Crisis prevention ▪ Trauma workshop ▪ Violence workshop
Addictions	<ul style="list-style-type: none"> ▪ AADAC Information ▪ Local workshops related to drug and addiction issues for youth ▪ Methadone training session (recruited physicians) ▪ Reality Check (drug information seminar) ▪ Community Drug Awareness Evening
Sexual Health	<ul style="list-style-type: none"> ▪ Sexual health conference ▪ Anti-homophobia
Other	<ul style="list-style-type: none"> ▪ Speaker training ▪ Ethics

Examples of reported evaluation results regarding knowledge and skills by staff, volunteers, students, and board members tended to be based on verbal, informal feedback. In some cases, training evaluations demonstrated increased knowledge (e.g., increased knowledge of HIV, hepatitis, and harm reduction among participating students). Organizations reported increased

staff knowledge on a variety of issues through attending presentations such as street culture, prison culture, injection drug use, gay men's issues, addictions and treatment.

Results regarding knowledge and skills acquired from training were usually based on anecdotal or self reports, and assumed from the provision of training and attendance at workshops that knowledge and skills were obtained. The exception was the increase in evaluation training forms used to assess satisfaction as well as knowledge gains.

The overall number of staff, volunteers, board members, clients, and students trained was not consistently reported.

A few promising practices were observed, however, with respect to monitoring and reporting organizational training opportunities. One agency reported that all training is tracked on a human resource information system. In other instances, standard evaluation forms were developed to evaluate workshops and training sessions.

Audited financial statements which include a diversity of funding sources [Indicator 1.3]

The evaluation did not include a review of audited financial statements; however, it was observed that several operational sites often described challenges and barriers to seeking out other funding sources. Some challenges included meeting the criteria of various funding agencies (e.g., health considers us housing, and housing considers us health) and extensive reporting requirements. Many operationally funded organizations identified the ACHF as their primary funding source.

Range of media used and range of target audiences for communication on programming and results. [Indicator 1.4]

Operational sites used a very broad range of media for communication on programming and results – as well as for the delivery of programs. Types of media included print (newspaper, magazines, newsletters, direct mail, pamphlets, posters, booklets, etc.), electronic (television, video, radio, internet), in-person (conferences, theatre, display booths, parades, public events), and other media (trivia games, chalk murals, a donated leased vehicle with the organizational logo).

Communication was directed at a broad range of target audiences including people living with HIV, health professionals, community partners, correctional institutions/prisons, members of the Aboriginal community, hotels and bars, media directly (as a target audience), educational institutions (e.g., high schools, colleges, universities), public libraries, dentists, businesses, beauty salons and tattoo parlours, film and arts community, injection drug users, and the general public. In some instances, resources were starting to be developed in languages other than English (such as French, Spanish, Chinese, Arabic) to increase the reach of programming and communication.

Feedback gained from service recipients [Indicator 1.5]

Feedback was gained from service recipients in a variety of ways ranging from anecdotal and informal methods to more formal assessment and evaluation. The most common level of

feedback was informal (e.g., sharing personal stories). Formal methods of soliciting feedback including surveys, client feedback forms, focus groups and interviews. Organizations reported that feedback was used to help plan and modify programming and to make programs and events more appealing to target populations.

Examples of the types of feedback gained from service recipients are provided in Table 7.

Table 7. Examples of Feedback Gained from Service Recipients

Category	Examples
Satisfaction with Services	<ul style="list-style-type: none"> ▪ Organizations commonly reported that service recipients were satisfied with services received and that they feel supported (e.g., clients receiving supports from peer support matches were grateful to talk with someone who is living with HIV and/or Hepatitis C). <p>Other examples of client satisfaction reported by organizations include:</p> <ul style="list-style-type: none"> ▪ Clients report “that the program has helped them connect with resources (e.g., psychologists, financial benefit workers) helping them to deal more effectively with their issues”. ▪ Clients were satisfied with information provided (e.g., needle exchange survey). ▪ Clients reported positive benefits of involvement with the organization. For example: “I am more confident and I have more self-esteem. I am also more hopeful and less isolated. I have friendships and support.” ▪ In another example (based on one organization’s client satisfaction survey), 90% of clients reported that the quality of services mostly or completely met their needs. 90% rated quality of life as very good or good. ▪ Positive comments about presented materials and speakers.
Appreciation for Services	<ul style="list-style-type: none"> ▪ Where applicable, organizations reported positive client feedback and appreciation for needle exchange programs. ▪ Other organizations reported that the special needs fund for PLWH was appreciated and valued by recipients. ▪ Appreciation for peer support and having someone to talk to (sometimes at the agency office) was also expressed.
Contrast from Mainstream Health System	<ul style="list-style-type: none"> ▪ Some organizations reported client feedback that the services received from ASOs is more positive than the negative experiences within the mainstream health system.
Impact of Organizational Change	<ul style="list-style-type: none"> ▪ Organizations reported negative feedback from service recipients with respect to disruptive organizational changes such as high staff turnover and/or frequent or unanticipated moves in office location. ▪ One organization reported, for example, that clients tend to resent changes in service providers and that it takes time to rebuild trust.

Evidence of routine data collection and analysis to assess strategic plans, goal attainment and to modify programming [Indicator 1.6]

Evidence of routine data collection and analysis to assess strategic plans, goal attainment, and to modify programming was minimal but increasing over the three year funding cycle. A range of challenges and successes/promising practices related to evaluation and routine data collection were observed. Some sites experienced challenges in conducting formal evaluations; other sites have reported well established data collection and monitoring activities.

Reported challenges and barriers as well as successes and promising practices related to evaluation and routine data collection are presented in Table 8 below.

Table 8. Challenges and Successes Related to Routine Data Collection and Evaluation

Challenges/Barriers to Evaluation and Routine Data Collection	Successes/Promising Practices Related to Evaluation and Routine Data Collection
<ul style="list-style-type: none"> ▪ Time constraints ▪ Competing priorities (service provision versus evaluation) ▪ Lack of appropriate evaluation instruments or tools ▪ Lack of human resources/expertise ▪ Staff turnover ▪ Transient populations ▪ Difficulty assessing behaviour change ▪ Development of the Evaluation Framework did not occur until midway through the funding cycle – thus, data was not initially collected with this framework in mind. ▪ An electronic database designed to monitor most of the quantifiable indicators (such as number of resources, number of training sessions, presentations, etc.) was used inconsistently and subsequently discontinued. ▪ When reported in written narrative reports, statistics on client service numbers, ages, counseling sessions provided, referrals, resources distributed, etc., were not always consistently reported by all sites. ▪ Challenge differentiating anecdotal information from qualitative evidence. 	<ul style="list-style-type: none"> ▪ Organizational leadership and support for evaluation and data collection. ▪ Progress on using the HOMES database to track progress was beginning to get underway for some organizations. ▪ Some organizations were beginning to develop internal databases to document information such as client demographics and program utilization statistics. ▪ Some organizations undertook strategic planning initiatives (both internally and externally facilitated) and used the results to provide more clarity to staff and overall programming. ▪ Evaluative client feedback was used to help modify programming when possible. ▪ Exploration of case studies and personal stories (e.g., through participatory action research frameworks). ▪ ACCH Skills Building Sessions and access to supports through ACCH (e.g., evaluation expertise) were cited as facilitators to increased integration of data collection and evaluation into the organization.

Participant interview feedback was consistent with the observation regarding the range of evaluation practice (from limited to extensive) and the challenges associated with assessing program outcomes. When asked to self-reflect and rate one’s organization on a scale of 1 to 10 (with 1 being limited evaluation and 10 being extensive evaluation and routine data collection integrated within the organization) the average score was 5.6 out of 10. The range of responses

varied from 2 to 8. One participant further commented that the rating would depend upon whose perspective the rating was made. For example, from a community standpoint (related to evaluation expectations) the organization would rate itself high (e.g., 7), but commented that from the funder's perspective the rating may be much lower (e.g., 3).

To what extent have target population members been involved in program development, delivery and evaluation, and in the governance of operationally-funded organizations? [Evaluation Question # 2]

As previously stated, target population members were involved in a variety of ways in operationally-funded organizations. The interpretation of target population involvement did not differ significantly across fund approaches. This was increasingly evident with respect to Strengthening Community Based Organizations which overlaps considerably with all of the other fund approaches. Thus, please refer to the other fund approaches for more information regarding the involvement of target population members in operationally-funded organizations.

To what extent is programming based on identified and projected community needs? [Evaluation Question # 3]

Similarly, the extent to which programming was based on identified and projected community needs did not differ when data was interpreted according the Strengthening Community Based Organizations fund approach. Thus, please refer to the other fund approaches for more information regarding community needs.

How do partnerships impact our HIV/AIDS programming? (Impact: contribute to effectiveness and sustainability) [Evaluation Question #4]

Qualitative information on and concrete examples of partner involvement in assessing needs, designing, implementing and evaluating projects, and reaching target populations; and on level of partnership [Indicator 4.1]

A large volume of partner involvement and partnership activities were reported. The level of partnership varied from minimal/nominal (e.g., through letters of support) to extensive (e.g., regular attendance and contributions during meetings, joint planning of special events and co-delivery of services).

Representatives from operational sites reported that partnership involvement was a critical piece of their work and that they made efforts to include as many relevant partners as possible. Representatives commented that organizations don't need help in identifying who their partners should be or emphasis on the importance of partnership development – i.e., organizations are doing this anyway as a natural component of operation. Commonly reported partners included health and social service professionals, local businesses, and other ASOs.

“Partnerships are critical to the work we do.” (interview)

“We certainly go after what we need.” (interview)

Reported benefits of partnering included increased opportunities for training and resource sharing, increased source of referrals, reduced pressure on the organization (through sharing of time, finances, staff, equipment, and information), increased availability of services to clients, and greater awareness and acceptance among partners regarding specific initiatives (e.g., increased acceptance of methadone programming by police and greater acceptance of harm reduction among corrections staff as a result of relationship building and time).

It was noted, however, that organizations may need to better define the level and type of partnership activities. Inauthentic partnerships were not seen as particularly helpful.

“With authentic partnerships, the actual sharing of resources has meant we can accomplish more than we can independently...An in-authentic partnership provides a letter of support to an initiative and that’s the extent of it...or the decision-making and resources are within one person’s hands...”

“If [ACHF/ACCH] had a tool or a method to rate partnerships...that’d be beneficial...A lot of the partnerships may be more supports.”

[In-kind donations and funding \(partnerships\) \[Indicator 4.2\]](#)

Some examples of in-kind donations and funding were reported including a range of in-kind supports such as staff time via participation on planning committees or co-delivery of services (such as partnerships to deliver needle exchange programs). Additional funding support was sometimes provided through partnership agreements for short-term project funding for specific initiatives (e.g., funding to organize a workshop).

[Reduced pressure on ACHF operational organizations’ resources through joint programming \(a long term indicator\) \[Indicator 4.3\]](#)

A few examples were observed in which joint programming contributed to reduced pressures on the organization. In one case, co-planning a conference was reported as a successful partnership initiative through sharing of time, finances, staff, equipment, and information. Similarly, partnership agreements (staff time) for the delivery of needle exchange programs were also reported as helpful. However, for the most part it was observed that partnership development and relationship building take time to evolve (recognition of the long term nature of this indicator). It may take considerable time before reduced pressure on organizations’ resources can be realized and sustained. Furthermore, partner organizations may also be facing resource constraints and may not always be in a position to reduce organizational pressure.

Some promising practices included the co-location of services (Health Village Model), co-sponsoring conferences and special events, and increased collaboration between agencies.

Challenges included the time consuming nature of committee work and the reality that partnership development takes time and resources.

Summary Comments Regarding Strengthening Community Based Organizations

Funding was used in a variety of ways to help increase the skills and abilities of the people who work at all levels of the community-based HIV movement including board, staff, and volunteers.

A variety of training and development opportunities were provided including general orientation training, education sessions to increase knowledge regarding HIV, and additional training regarding a variety of specific topics including culture and diversity, research and evaluation, health and social services, peer support, volunteer recruitment, board development, fund development, harm reduction, facilitation, team building, crisis intervention, addictions and sexual health.

A common challenge reported by operationally-funded organizations, however, related to staff retention and recruitment. Staff turnover occurred within all operationally funded organizations throughout the three-year funding cycle.

Another common challenge emerged with respect to formal data collection and evaluation. However, progress was being made throughout the three-year funding cycle with increased attention to data collection activities such as workshop evaluations.

Partnerships also represented a significant component of efforts to strengthen community based organizations. A wide range of partners were engaged to help reduce pressure on organizational resources (long term) and to better meet the needs of client populations.

7.0 Harm Reduction

Harm Reduction: To reduce the negative consequences of high risk behaviour in the community such as injection drug use, and to ensure the safety of individuals.

Corresponding Evaluation Questions:

- To what extent have target population members been involved in program development, delivery and evaluation, and in the governance of operationally-funded organizations? [Evaluation Question #2]
- To what extent is programming based on identified and projected community needs? [Evaluation Question #3]
- How have we contributed to enhancing the capacity of PLWH to lead safer and healthier lives? [Evaluation Question #7]
- How have we contributed to target populations' awareness, attitudes, knowledge, skills and access to resources (supports) that enable them to lead safer and healthier lives? [Evaluation Question #9]

Note: All of the above evaluation questions have already been addressed within the preceding fund approaches with the exception of the indicator regarding needle distribution and exchange. Examples pertaining to harm reduction were embedded within previous descriptions. The following section of this report includes needle distribution statistics as well as summary information as it applies to harm reduction.

Operational Sites

Number of needles distributed in the province annually, from # of locations [Indicator 7.6]

More than 4 million needles were distributed across the province through 8 operationally funded organizations during the first three year funding cycle. Some organizations distributed needles from multiple and/or mobile locations (via traveling van).

The number of needles distributed per organization is outlined in Table 9. Some sites also maintained records of the number of needles returned (exchange rate) and reported a very high percentage of returned needles (e.g., often 90% or more). A number of factors intervened with return rates such as the introduction of needle drop boxes (i.e., in some cases more needles being disposed of in needle drop boxes made numbers returned to organizations appear to drop).

Organizations reported a range of lessons learned regarding needle distribution. Building and maintaining trusting relationships with clients was noted as one of the most important factors for successful program delivery. In addition, organizations reported lessons learned regarding

reciprocity (encouraging needle returns) as well as client preferences for needle types, locations, and service.

Table 9. Number of Needles Distributed in the Province (ACHF Harm Reduction Funding)

Organization	Year 1a April 01- Oct 01	Year 1b Nov 01- Mar 02	Year 2a Apr 02- Oct 02	Year 2b Nov 02- Mar 03	Year 3a Apr 03- Oct 03	Year 3b Nov 03- Mar 04	Total	% OF OVERALL TOTAL
CAANS	46,479	43,704	47,194	36,174	27,489	35,503	236,543	5.86%
HANSEAA	--	--	960	3,250	5,480	6,555	16,245	0.40%
HIV North	8,141	13,264	9,482	6,690	8,899	13,830	60,306	1.49%
Lethbridge	1,050	2,350	5,130	6,710	6,310	9,630	31,180	0.77%
Safeworks	210,000	195,066	233,515	210,000	207,000	184,465	1,240,046	30.72%
Streetworks	439,330	397,540	439,215	385,100	398,031	392,436	2,451,652	60.75%
	705,000	651,924	735,496	647,924	653,209	642,419	4,035,972	100.00%

Overall Harm Reduction Activity: Operational Sites

Harm reduction programming included more than needle distribution. Access to health and social services, referrals to other agencies, condom distribution, and support from staff were elements commonly integrated with needle distribution programs.

In addition, organizations worked with a range of key stakeholders (including health professionals, community agencies, students, etc.) to increase understanding and to promote acceptance of the harm reduction philosophy.

In some locations, methadone programs were also introduced during the three-year funding cycle. These programs were not funded by ACHF although several operationally-funded organizations contributed to lobbying for this service on behalf of their clients.

Overall Harm Reduction Activity: Project Sites

Harm reduction activities undertaken within the time limited projects tended to focus on awareness building activities (e.g., general public awareness of harm reduction, pharmacist awareness and information). Very little direct service provision for harm reduction was reported with the exception of one project involving the placement of needle drop boxes.

Summary Comments Regarding Harm Reduction

Organizations worked to provide harm reduction activities to reduce the negative consequences of high risk behaviour in the community such as injection drug use, and to ensure the safety of individuals. Over one million needles were distributed annually across at least 8 central locations (with many additional satellite or traveling sites). Access to health and social services, referrals to other agencies, condom distribution, and support from staff were elements commonly integrated with needle distribution programs.

In some locations, methadone programs were also introduced during the three-year funding cycle. These programs were not funded by ACHF although several operationally-funded organizations contributed to lobbying for this service on behalf of their clients.

In addition, work with key stakeholders was undertaken to influence attitudes toward the harm reduction philosophy and approach.

Harm reduction programs, activities, and awareness building opportunities have been provided throughout the province. Are these activities making a difference? Feedback from operational site representatives suggests that attitudes are changing (toward increased acceptance of harm reduction) but that change has been slow and incremental. The trend toward decreased numbers of new HIV cases within the IDU population (based on the provincial infectious disease data report) could also be interpreted to suggest that the harm reduction activities were beginning to make an impact.

8.0 Discussion and Recommendations

What lessons have we learned about the effectiveness of our approaches? [Evaluation Question #10]

Complete understanding of the effectiveness of approaches requires comprehensive evaluation of those approaches. Given the several identified barriers to routine data collection and evaluation it is difficult to make broad conclusions regarding the effectiveness of approaches.

However, operationally-funded organizations and project sites reported a range of lessons learned regarding the effectiveness of approaches. Lessons learned were based on personal and professional experience as well as feedback from program participants.

Specific examples of lessons learned have been included throughout the main body of this report. Overall broad examples of reported lessons about the effectiveness of approaches included the following:

- Programs are more successful if they involve key stakeholder and target population participation (e.g., programs delivered by and for youth, Aboriginal communities, street involved populations, etc.).
- Consistent and skilled human resources are critical for program effectiveness.
- Flexibility and informal activities are important characteristics of effective programs.
- Authentic partnerships can help to facilitate successful program delivery.
- Trust and relationship building with clients and partners provide the foundation of successful program delivery.
- HIV issues are complex and outcomes are not always easily measured.

What are the identified best practices for each of the five ACHF approaches? [Evaluation Question #11]

Interview participants reported that the term “best practices” is somewhat problematic and that it is difficult to determine what constitutes best practice (a common challenge in health and social service programs). Alternate terms were preferred including good or promising practices. Several promising practices were identified throughout the evaluation process. Examples of promising practices for each fund approach are outlined below.

Creating Supportive Environments

- Outreach activities to bring the services to individuals where they are needed most.
- Delivery of multiple health and social services in one location (to increase access and availability of services to clients).
- Partnership development and communication with health professionals and other service providers (e.g., police, corrections staff) to reduce stigma and increase awareness to help reduce barriers to accessing health and social services.

Health Promotion for People Living with HIV

- Direct involvement of people living with HIV in the management of their condition (e.g., individual level goal planning and goal attainment evaluation).
- Attention to basic needs and provision of a stable environment.

Prevention

- The use of non-stigma based advertising and promotion to generate awareness and promote knowledge of HIV prevention.
- Multiple methods used to communicate prevention messages to a broad range of target populations.

Strengthening Community Based Organizations

- Development of human resource databases and program monitoring systems (e.g., to track staff and volunteer training, client demographics, program utilization, etc.).
- Development of standard forms to evaluate workshops and training sessions.
- Co-sponsoring conferences and special events.
- Increased collaboration between agencies.
- Organizational leadership and support for evaluation and data collection.
- Progress on using the HOMES database to track progress was beginning to get underway for some organizations.
- Some organizations undertook strategic planning initiatives (both internally and externally facilitated) and used the results to provide more clarity to staff and overall programming.
- Evaluative client feedback was used to help modify programming when possible.
- Exploration of case studies and personal stories (e.g., through participatory action research frameworks).
- ACCH Skills Building Sessions and access to supports through ACCH (e.g., evaluation expertise) were cited as facilitators to increased integration of data collection and evaluation into the organization.

Harm Reduction

- Partnership development with other agencies (e.g., sharing staff time to deliver programs).
- Emphasis on principle of reciprocity to increase needle exchange rates.
- Work with key stakeholders to promote acceptance and understanding of the harm reduction approach.
- Involvement of target population members (e.g., involvement of “natural helpers” within the street population, injection drug use clients invited to help clean up sites if possible, etc.).

Overall Summary Comments

Complexity was a key theme to emerge throughout the evaluation. It was evident that organizations were engaged in very difficult work with often high risk, transient populations, with complex needs. Organizations reported common frustrations and challenges including staff turnover, complex client populations, high workloads, and funding concerns.

A high volume of activities was observed. Operationally-funded and project sites contributed to each of the five fund approaches in a multitude of ways including the delivery of thousands of presentations, workshops, training sessions, and public awareness campaigns; distribution of

millions of needles and thousands of condoms; provision of peer support; care and support for people living with HIV; client advocacy; partnership development; and many other activities.

Evaluation was a challenging aspect of the work undertaken by operationally-funded organizations and project sites. A high volume of activities and outputs were reported, although numbers were not always consistently documented within and across organizations. Several factors were related to this challenge including lack of time, resources, and competing demands of front-line service provision. It was also evident, however, that changes were underway during the three year funding cycle. For example, a trend was observed toward increased use of evaluation forms to assess changes in knowledge and attitudes as a result of program participation.

Key stakeholder passion and dedication was also observed throughout the evaluation process among those organizations where primary staff members had stayed with the organization throughout the duration of the three-year funding cycle and beyond. Interview participants expressed a desire to make a difference and resilience to continue despite the identified challenges, barriers, and complexity of working in the field of HIV.

Recommendations

1. Implement a recognition system for good or promising practices.

Organizations would benefit from a system to recognize and increase awareness of good or promising practices. Such a system may build on existing structures for sharing information (e.g., ACCH skills building sessions).

2. Increase available support, training, and resources for evaluation.

Ongoing organizational support and training in evaluation and data collection methods would help to increase consistency in reporting. Organizations expressed appreciation for the supports that were already available (e.g., skills building and access to evaluation expertise through the ACCH); however, it was consistently noted that more resources (time, human, and financial) would be helpful.

Training in the use of common tools and reporting formats, with flexibility to adapt to local circumstances, would facilitate the overall evaluation process. Similarly, staff training or access to human resources with expertise in qualitative research methods may help to generate credible qualitative evidence in circumstances where it is difficult to quantify change.

3. Further explore partnership assessment criteria.

Given the critical role of partnership development, and the variability reported in terms of type and levels of partnership, some organizations may benefit from the development of tools (or the identification and dissemination of existing tools) to help assess partnerships.

4. Improve mechanisms for information and resource sharing

A large volume of information, resources, and other materials were generated throughout the three-year funding cycle and submitted through regular reporting periods to the ACHF. Other organizations may benefit from increased opportunities to access these types of materials to avoid duplication of effort. For example, a central repository or searchable database of available resources might be a useful tool for organizations considering new approaches.

5. Revisit the evaluation framework

Given that the evaluation framework has now been applied to a full funding cycle, it is recommended that the framework be reviewed to assess current relevance and level of stakeholder acceptance.

Key questions to guide the review of the evaluation framework may include: What is working well? What challenges exist? What improvements to the evaluation framework do key stakeholders recommend? Is the right information being captured for the 2004-2007 funding cycle? Do the indicators correspond to the evaluation questions? Are the indicators measurable? Is there overlap in indicators? What aspects of the evaluation framework generate the most and least useful information? To what extent do representatives from operationally-funded organizations support the evaluation framework?

6. Revisit project funding criteria

It may be helpful to revisit the funding criteria for time-limited projects. Project funding was intended to fund time-limited (one year in duration), specific activities that addressed unmet needs and priorities relating to HIV. For the most part, funding was applied to some of the priority areas including prevention-oriented programming in the youth and Aboriginal communities. Project funding was also used to address unmet needs (such as peer support training) although it is unclear the extent to which sustainable changes with respect to unmet needs occurred as a result of the short-term projects.

Project funding may better be distributed over a longer time frame and delivered through or in partnership with existing operationally-funded organizations with demonstrated capacity to plan, deliver, and evaluate programs.

7. Create and implement a document review and management system

The overall evaluation of the ACHF could be facilitated by the development of an electronic document review and management system. The system could include a process such that when six-month narrative reports are submitted by organizations, an ACHF representative or designate extracts relevant information from each report according to the evaluation framework questions and indicators and subsequently enters this information into an electronic spreadsheet or database. This system could be used to identify issues and to facilitate follow-up with organizations to fill gaps in information.

Concluding Comments

A great deal of activities intended to create supportive environments, facilitate health promotion for people living with HIV, prevent HIV among populations known to be vulnerable, reduce the negative consequences of high risk behaviour, and strengthen community based organizations were reported during the first three-year funding cycle. An evaluation framework was introduced part way through the funding cycle and organizations were encouraged to conduct routine data collection to help increase understanding regarding the impact of these activities. Progress, growth, areas for improvement, promising practices, and lessons learned were identified and have been summarized in this report to serve as a basis for reviewing, planning, and evaluating subsequent funding cycles.

Appendix A: Evaluation Framework