Alberta Community HIV Fund

Roll-up evaluation of ACHF funded activities

2007 - 2010

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Birgitta Larsson, M.Sc.
308, 12111 – 51 Ave
Edmonton, AB T6H 6A3
Telephone/Fax: (780) 988 9420
Email: birgitta@bimlarsson.ca
www.bimlarsson.ca

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Executive Summary

Introduction

The Alberta Community HIV Fund (ACHF) is a joint community/provincial/federal funding model providing operational funding for AIDS service organizations (ASO) in Alberta. During the period of this evaluation roll-up a total of 13 organizations received funding in Alberta.

The projects carried out by ASOs target those vulnerable populations currently most affected by the epidemic and identified as priority populations: people living with HIV/AIDS, gay men, injection drug users, Aboriginal people, prison inmates, youth and women at risk for HIV infection, and people from countries where HIV is endemic.

Each funded organization is required to report on a semi-annual basis on activities, outputs and outcomes. A roll-up of this evaluation data was completed. The overarching focus of the evaluation roll-up was to capture: *To what degree are the ASOs in Alberta moving towards the stated outcomes*?

Methods

The following data was included in the roll-up:

- Harmonized Outcomes Measurement for Organizational Reporting to the Alberta Community HIV Fund reports from November 2009 (n=13) and April 2010 (n=12)
- *ACHF Evaluation 2007/2008: Assessing the Outcomes*[1] (used as baseline)
- *ACHF Evaluation 2008-2009 Assessing the Outcomes*[2] (used as the progression data)
- Primary data was collected from four key stakeholder groups.

Findings

Overall, based on the secondary data the following trends support that short term outcomes in the Provincial Evaluation Framework are being met:

- ASO are increasingly reaching other sectors by sharing resources developed for the HIV/AIDS target population and providing education training sessions for service providers.
- ASOs have intensified their work with policy makers. There appears to be a shift away from influencing policy and practice within other organizations through education and partnerships to a more direct approach of meeting with policy makers.

[1] Christine Leonard Consulting Ltd. May 14, 2009

[2] Christine Leonard Consulting Ltd. July 28, 2009

- Target populations are involved in all aspect of program development, delivery and governance. Volunteers are involved in all aspect of the ASOs.

- There is an increase in reach and diversity of partnerships over the last three years.

- The staffing structure shows increased stability. Staff and volunteers receive training and gain new skills from this training.

- Clients living with HIV/AIDS have access to services and they are satisfied with the services they receive.

- Clients report increased knowledge of HIV related issues.

- ASOs are beginning to adopt a systematic approach of gauging results from their education/workshop sessions including active monitoring of target populations' access to services.

Areas that appear to have challenges

Overall, based on the secondary data the following trends do not support that short term outcomes in the Provincial Evaluation Framework are being met:

- There is a decrease in total number of contacts made with target populations and a shift in type of populations reached. There are also indications that there is a need to define "those most at risk populations".

- With an increasing population in Alberta of people from countries where HIV is endemic ASOs need to reach greater proportions of this population. There is little evidence that this population is being targeted.

- Access to safer sex resources has decreased over the past three years.

- There is a 13% decrease in the total number of contacts made within the harm reduction programs.

- There is a 5% reduction in number of contacts with PLWH.

- ASOs report a 15 times increase in contacts made with the general population over the past year. This has been carried out through multiple avenues such as presentations, media coverage and sharing information with other organizations. Considering the limited resources available to ASOs to what degree should ASOs target their effort within this population?

Recommendations

Based on the trends reported above the following recommendations are made:

1. Define target populations and develop strategies to reach them

With limited resources it is imperative that ASOs are strategic and explicit in their interventions. To facilitate this ASOs should together with funders and based on available research clearly define who the target populations are within Alberta. The populations '*most-at-risk'* should be clearly define and resources should be allocated to reach these populations. These definitions should be specific to include the type of sub-populations, population characteristics, access points, any specific defining characteristics such as behaviours, gender, age, location, patterns, types of risks, etc.

Once the populations have been clearly defined and agreed upon, specific strategies should be developed by each ASO in relation to the population they are targeting. This should be based on excepted best practices and strategies that are known to be effective in reaching these populations.

2. Improve data collection

The overall roll-up of reported outcomes for the 13 ASOs in Alberta proved to be a complex and difficult activity partly due to irregularities with the secondary data. In order to enhance the confidence in the data and to support the ongoing collection of valid data the data collection process, structure, and training should be improved.

3. Use evaluations to improve practice

The ASOs invest extensive resources in completing the semiannual submissions; however, this work does not appear to be used by the organizations internally. Evaluation is about knowledge generating and should support agencies in their planning and strategic activities. It should provide findings that are relevant, timely and insightful. Evaluations should not only address questions related to *"what and to what degree*" but more so answer the questions related to "*how and why something resulted*".

ASOS must begin in a constructive way to use the data they collect within their organizations. They must begin seeing the value of evaluative work and data. This can only be done if they define the data sets that are important and helpful to them and their organization. This should be done jointly by all the ASOs and form the basis for the new improved data collection structures.

1.0 Introduction

The Alberta Community HIV Fund (ACHF) is a joint community/provincial/federal funding model providing operational funding for AIDS service organizations (ASO) in Alberta. The model was developed through consultation with representatives from Alberta community-based HIV organizations, persons living with HIV/AIDS, the regional health authorities, and provincial and federal health departments[3].

ACHF goals are addressed by funding community organizations that provide prevention and health promotion activities for at-risk populations and that create supportive environments for people living with HIV/AIDS, and by strengthening community organizations whose work directly or indirectly addresses HIV/AIDS and related health and social conditions. The projects carried out by these organizations target those vulnerable populations currently most affected by the epidemic and identified as priority populations: people living with HIV/AIDS, gay men, injection drug users, Aboriginal people, prison inmates, youth and women at risk for HIV infection, and people from countries where HIV is endemic. ACHF funded organizations may also target health professionals, other types of practitioners, and policy and decision makers. During the period of this evaluation roll-up a total of 13 organizations received funding in Alberta.

Alberta Community Council on HIV (ACCH) is an umbrella organization with a mandate to provide supports to community-based ASOs and provide provincial leadership through collective action and unified voice[4]. ACCH is also funded through ACHF.

Each funded organization is required to report on a semi-annual basis on activities, outputs and outcomes. An evaluation framework has been established to guide the evaluation and agencies by reporting in relation to eight program domains.

The overarching focus of the evaluation roll-up was to capture: *To what degree are the ASOs in Alberta moving towards the stated outcomes*?

To answer the evaluation question a step-by-step approach was used. First an aggregated roll-up of program reports related to scope and outcomes for 2009/2010 as reported by ACHF funded agencies in Alberta was conducted. Second, these findings were compared with aggregate findings from 2007-2009, when available. Finally, the outcomes were contextualized by conducting interviews with key stakeholders familiar with ACHF.

The work was guided by five basic principles:

- **Outcomes based:** The work focused on capturing the outcomes that have been achieved over the last year (not outputs).
- **Utility:** The evaluation was utilization focused, to allow easy use and with targeted users in mind. This included short concise reporting style of final deliverables[5].

[3] Alberta Community Council on HIV. What is the Alberta Community HIV Fund. Retrieved May 13, 2010. http://www.acch.ca/alberta_community_hiv_fund.html

[4] Alberta Community Council on HIV. Home page. Retrieved May 13, 2010

- **Constraints and limitations**: The evaluation was designed to increase (to the greatest degree possible) data confidence (triangulation). The evaluation was completed within the resources and time limitations that existed.
- **No additional burden**: The evaluation work used existing data, striving constantly to reduce additional burden to ASOs.
- **Ethical**: The evaluation was conducted in an ethical manner using ARECCI framework, recognizing in particular issues related to confidentiality, privacy, data sources, methods and burden.

2. Methodology

The evaluation roll-up used both primary and secondary data sources. The main focus was on secondary data contained in reports submitted by ASOs in Alberta over the last year (2009/2010). Operational output data and program results were used as the foundation to assess to what degree the stated short and intermediate term outcomes had been met.

The second step was to compare the findings from 2009/2010 with aggregate findings from the same organizations during two previous reporting years.

The roll-up was guided by the ACHF Evaluation Framework and contextualized by in-person interviews with key stakeholders. The overall national AIDS Community Action Program (ACAP) Evaluation Summary Report 2007-2009[6] was also used as a reference.

2.1 Secondary Data Sources and Analysis

Harmonized Outcomes Measurement for Organizational Reporting to the Alberta Community HIV Fund reports from November 2009 (n=13) and April 2010 (n=12) were used as the primary source of information. Of the 90 areas of inquiry, 40 questions were identified as measuring outcomes or acting as proxy measures for outcomes. A matrix was developed to capture outcomes related to each of the eight domains. See Appendix A for a copy of the matrix.

The data from the 25 submissions were dissembled and raw data were produced to ensure that inappropriate weighting did not influence the findings. A data-base was developed with the 40 key questions to allow analysis and review in relation to the eight key domains. This process revealed data flaws addressed in 3.0 Limitations.

The data were entered into an Excel data base and an analysis using descriptive statistics was completed on quantitative data. Qualitative data was coded using thematic analysis. To ensure the confidentiality of each of the ASOs percentages were used as the basis of reporting.

The change over time review applied the findings (when available) from the *ACHF Evaluation 2007/2008: Assessing the Outcomes*[7] as the baseline for each of the eight domains. At times this proved to be difficult since the Evaluation Framework was updated in 2008 and data

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[5] Canadian Health Services Research Foundation 1:3:25 mandated reporting structure

[6] Natalie Kishchuk Research and Evaluation Inc.

[7] Christine Leonard Consulting Ltd. May 14, 2009

collection and reporting changed as a result. Hence, the reporting domains were not always comparable

ACHF Evaluation 2008-2009 Assessing the Outcomes[8] was used as the progression data for capturing change over time for each of the eight domains and on several measures as the baseline data.

Project Evaluation and Reporting Tool (PERT) revised reports submitted by ACCH from June 2009 and December 2009 were also reviewed and analyzed. This data were not included in the data base due to different reporting structure.

Alberta Community Council on HIV 2010-1013 Strategic Plan was assessed for its alignment and relationship with the findings from ASO reports as well as the yearly reports by ACCH.

2.2 Primary Data sources and Analysis

Primary data were collected to provide context to the findings and to understand some of the historical changes that have influenced the evolution of the program.

Primary data was collected from four stakeholder groups:

- ACCH Board of Directors (focus group n=4)
- Executive Director ACCH (interview n=1)
- Funders (interview with PHAC and AHW representatives n=3)
- Fund Steward (n=1)

The interviews followed the questions outlined in the Matrix presented in Appendix A.

3.0 Limitations

The roll-up of the evaluation findings contained major limitations. The main ones are highlighted below:

1. Due to limitations and inconsistency in the secondary data, accepted quantitative data analysis rigor could not be applied.
2. Lack of definitions, instructions and rules for interpretation within the tool resulted in reports having major flaws leading to low confidence of the data.
3. (Re)-coding of raw data from 2009/10 was conducted for many of the questions to enhance the validity of the data. This revealed major calculation errors in quantitative data.
4. Information from 07/09 and 08/09 were provided in aggregate form therefore weighting issues could not be assessed.
5. Major redesign of the Evaluation Framework was completed in 2008 limiting available baseline data from 2007/08. Most of the comparisons data are from 08/09.

[8] Christine Leonard Consulting Ltd. July 28, 2009

4.1 Trends

Due to the limitations of the data, this report should be treated as representing overall trends. Caution should be applied when referencing specific data sets since it is the context of the data that provides strength to the findings.

The information below outlines the findings for each of the eight target areas. Each section is presented in five segments:

- Overall goal
- Indicators used for measuring this goal (these corresponds to specific questions outlined in the evaluation matrix Appendix A).
- 2009-2010 results. In the text data from 2008/09 is presented in brackets. When available, data from 2007/08 are presented as well.
- Discussion
- Conclusion

4.1 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.

Indicators:

- Target population reached
- Media coverage
- Service providers increase in knowledge
- Access to information and education

2009-2010 results (2008/2009)

Overall reach
ASOs in Alberta made contact with over half a million people of the general public 575126 (33,932) over the last year. I addition, they contacted 24,119 (22,987) practitioners and professional, and 6,368 (2,698) policy makers.

They also conducted 213 (245) van ride-along with 48 (64) agencies.

Media Coverage
There were 997 (473) points of media coverage over the year with radio being the most common media coverage with 716 occurrences reported. Newspaper articles were the second most common media coverage with 116 (189) reported activities. Data from 2007/2008 noted 280 points of media coverage with newspaper articles (118) being the most common.

Education and awareness sessions
Workshops and presentations are a major part of service delivery for the ASOs in Alberta. As can be seen in the tables below over 6000 different type of sessions were held throughout the year.

Session outputs

Year	# of education session	# of contacts	% general population	% target population
07/08	949	29,951	70%	30%

08/09	773	48,656	59%	41%
09/10	6318	25, 983	61%	39%

Service providers' change in knowledge
68% of the ASOs reported they assessed change in knowledge of service providers who attend workshops and training sessions. In total n=884 (324) surveys were completed by service providers. The reported changes in knowledge of HIV/AIDS are shown below.

	08/09 (%)					**09/10 (%)**				
	E	VG	G	F	P	E	VG	G	F	P
My knowledge of HIV/AIDS before workshop	4	18	-	-	-	5	20	35	33	7
My knowledge of HIV/AIDS after the workshop	20	56	-	-	-	36	56	7	2	0

(E=excellent, VG=very good, G=good, F= fair, P=poor)

Service providers' comfort
Service providers' reported willingness and comfort with addressing HIV testing and discussing safer sex practices had also increased as seen below. Data from 08/09 is not available.

As a result of this workshop I am more…

	Yes (%)	**No (%)**	**Not Sure (%)**	**Not appl. (%)**
Encouraged to talk about HIV testing with my clients/peers.	87	3	7	3
Comfortable talking about safer sex practices with my clients/peers	90	1	6	3

ASOs are requested to track the type and number of resources distributed over the year. The table below shows the full distribution for 09/10 and 6 months distribution rates for 08/09.

Material	**# distributed**		**% general population**		**% target population**		**% material used by other orgs**	
	08/09	**09/10**	**08/09**	**09/10**	**08/09**	**09/10**	**08/09**	**09/10**
Manuals	2338	468	96	59	6	41	-	59
Brochures	55391	145297	3	87	97	13	-	57
Communiqués	50849	91737	99	99	1	1	-	60
Workshops Presentations	338	982	97	97	3	3	-	54
Website*	-	262711	-	-	-	-	-	-
Research	418	760	100	95	0	5	-	67
Other	24677	137911*	6	90	94	10	-	42

* # of reported hit to websites
* probably website hits

Data from 2007/08 indicated that 110 different types of resources were used and 85,898 copies of the material were distributed.

Discussion	ASOs reach far into Albertans population. With over half a million

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<td>contacts over the past year there is a potential for close to 8% of Alberta's population having had some contact with an ASO. This is a marked increased (15 times) over the previous year.

Contacts with service providers remain stable from previous years.

Contacts with policy makers have more than doubled, suggesting that ASOs are focusing their efforts for change in Alberta by reaching decision makers.

Media coverage has had a three-fold increase over the last three years. It has doubled in frequency over the past year, and shifted away from newspaper to radio being the most common medium.

There has been a seven-fold increase in the number of education sessions held over the last year. However, these resulted in only half of the number of people reached as compared to previous year. This drastic change in number of sessions may be a result of reporting error or change in activity coding within the organizations.

The majority of sessions targeted the general population. This is similar to last year.

There is a 172% increase in the population who were asked to complete workshop evaluations. This shows ASOs are increasingly committed to measuring participant change resulting from education sessions.

As can be expected there is an increase in participants' reported knowledge and comfort with the topics immediately following the sessions. These are similar to previous year.

Much material is distributed by ASOs across Alberta each year. The correlation between printed material and desired changes in behvaiour is still not proven. However, there are some interesting trends in the data:
The number of presentations and workshops has tripled over the last year.
The number of research papers/position papers distributed has nearly doubled.
The majority of the material is used by other organizations.</td>
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<td>Conclusion</td>
<td>ASO have increased their reach into the general population over the past year. This has been carried out through multiple avenues such as presentations, media coverage and sharing information with other organizations. Even though this is commendable work it is not a specific ASO target population.

ASO are increasingly reaching other sectors by sharing resources developed for the HIV/AIDS target population and providing education and training sessions for service providers.</td>
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	ASOs have intensified their work with policy makers. This work has more than doubled in the number of contacts over the last year. ASOs are beginning to adopt a systematic approach of gauging results from their education/workshop sessions.

4.2 Health Promotion for People Living with HIV/AIDS: To increase the capacity of people living with HIV to manage their condition and provide support for people affected by HIV.	
Indicators:	• Target population reached • Increased knowledge • Access to support • Access to 24/7 intensive and end-of-life care
2009-2010 results (2008/2009)	*Clients* According to PHAC[9] from November 1, 1985 to December 31, 2008 4,989 positive HIV tests were reported in Alberta. This prevalence data should be used cautiously since PHAC states that surveillance data understate the magnitude of the HIV epidemic and consequently do not represent the total number of people infected with HIV (prevalence) or the number newly infected each year (incidence). AHW's reported incidence rate for 2008 was 234 new diagnosed cases, a rate of 6.69 cases per 100,000. Over the last year approximately 1200 clients living with HIV received service through the ASOs health promotion programs in Alberta.

Year	April -Sept	Oct- March
07/08	364	274
08/09	1063	1064
09/10	1202	754*

* one organization did not report.

Contacts

The number of contacts made through the health promotion programs during the past year can be seen below.

Population	# of contacts 08/09	# of contacts 09/10
People living with HIV/ADIS	9912	9433
Those affected by HIV/AIDS	512	7313

9

Assisted Living

Two organizations provide assisted living options. The scope of service is presented below.

Output	2007/2008 Total	2008/09 Apr-Sept	2008/09 Oct-Mar	2009/2010 Apr-Sept	2009/2010 Oct-Mar*
# PLWH served in 24/7 intensive care	2	4	4	3	2
# of days of 24/7 intensive care	112	61	50	34	35
# of PLWH served in long term care	1	20	20	21	17
# PLWH residents served in transitional care	1	5	3	7	4
# of PLWH non-residents served in transitional care	6	5	4	9	5
# of residents who passed away	-	4	1	1	2

* one ASO did not report

Client feedback

Eight agencies (6) have over the last year measured 168 (56) PLWHs' increased knowledge, health opportunities and access to support. Respondents were asked to provide feedback related to their level of agreement with several statements. The scale had five measures: strongly agree, agree, neutral, disagree, to strongly disagree.

Statement (N=168)	Strongly agree	Agree	Neither	Disagree	Strongly disagree
I am more knowledgeable about HIV related issues because of the support of this agency.	47	35	13	1	2
The service provided to me are useful and appropriate to my needs	63	30	4	1	2
Because of the Agency support, I feel I am able to get the health services I need	53	36	8	2	2
Staff members support me to be in contact with my family and friends..	40	40	17	2	2
I am invited to participate in the decision about the services I receive	48	40	9	3	1
Staff members treat me with dignity and respect	76	21	3	0	0
I am satisfied with the	61	32	3	2	2

	quality of the services I receive.
	This agency provides me and my loved one with non-judgmental supports. 57 23 8 7 5
	Aggregate data (n=56) from 08/08 indicated that 96% of respondents were more knowledgeable about HIV related issues because of the support they received from the agency; and 97% indicated agency staff treated them with respect and dignity, and 100% indicated the agencies provided non-judgmental support. No further detail was provided.
Change over time	Over the last two years, the number of PLWH client contacts decreased by 5%. There has been a large increase in contacts made with persons affected by HIV/AIDS. The two organizations that provide assisted living support to clients maintained similar level of service as previous years. PLWH report increased knowledge about HIV related issues. 2% of clients provided feedback on services received. The large majorities of clients providing feedback agree or strongly agree that services meet their needs and they are treated appropriately and respectfully. The lowest level of agreement is noted in "staying in contact with family and friends" where 21% did not agree with the statement.
Conclusion	The limited sample that provided feedback indicated that: • Clients living with HIV/AIDS have access to services. • Clients living with HIV/AIDS in general are satisfied with the services they receive. • Clients report increased knowledge of the HIV related issues.

7 http://www.phac-aspc.gc.ca/aids-sida/publication/survreport/2008/dec/pdf/survrepdec08.pdf

4.3 Prevention Initiatives: To prevent HIV in populations known to be vulnerable to HIV.	
Indicators	• Increased knowledge • Access to safe sex resources • Organizational partnerships established

2009-2010 results (2008/2009)

Target populations

Last year saw a reduction in the total number of reported contacts with the target populations. It was primarily due to a decrease in contacts within the PWUID and Youth at Risk populations. Contacts with MSM and Aboriginal populations have more than doubled. It should be noted that 75% of Aboriginal contacts were reported by two ASOs. Data were not available for 2007/08.

Population	2008/09	2009/2010
Gay men/MSM	4575	10,793
People who use injection drugs	25,712	15,663
Aboriginal people	2924	6194
Prison inmates	697	1477
Youth at risk	23,497	16,297
Women at risk	3694	5158
People from countries where HIV is endemic	702	2157
Total	61,801	57,739

Access to resources

Access to safe sex resources has increased over the past year with over 50%, however it is still below 2007/08 levels. Testing and counseling sessions are reported at similar level to previous year.

Output	2007/08	2008/09	2009/2010
# of condoms	463,266	211, 238	337,124
# of test	2392	2278	2619
# of pre-test counseling sessions	-	2292	3011
# of post-test counseling sessions	-	2058	2065

Clients' transmission and risk knowledge

85% of ASOs reported they measured clients' change in knowledge as a result of attending workshops.

Statement (n=1770)	Excellent	Very good	Good	Fair	Poor
My knowledge of HIV/AIDS before the workshop was:	7	13	32	40	8
My knowledge after the workshop was:	35	48	15	2	1

Most respondents indicated they have more knowledge of how to protect themselves. However, 21% of respondents are not sure or think they can be infected from "French kissing" a person who has HIV.

Statement (n=1734)	Yes	No	Not sure
As a result of this workshop, I have more	96	3	2

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<tr><td>knowledge about how to protect myself from HIV.</td><td></td><td></td><td></td></tr>
<tr><td>There is a good chance of contracting HIV from “French” kissing someone who is HIV positive.</td><td>7</td><td>79</td><td>14</td></tr>
<tr><td>If I were going to have sex, I would talk to my partner about using condoms*.</td><td>89</td><td>2</td><td>5</td></tr>
</table>
* 4% indicated n/a

In aggregate data from 08/09 it was reported that 92% of high risk respondents (n= 2144) indicated they had increased knowledge of HIV/AIDS after attending a workshop.

86% of respondents (n=1067) indicated the correct answer to whether or not HIV can be contracted through French Kissing.
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<tr>
<td>Change over time</td>
<td>There has been 7% reduction in the overall contacts made with target populations. Most of this stem from reduction in contacts with Youth at Risk and PWUID. However there has been a marked increase in contacts with:

People from other nations where HIV is endemic. Three organizations report the majority of these contacts;
Prison inmates;
MSM population;
Aboriginal population. 72% of the contacts are reported by two ASOs.

As seen before, there is an increase in ASOs reporting using surveys for feedback. However, there is a 30% decrease in completed surveys from at-risk populations about their predicted behavior following attendance at a workshop.

Over the three years there is a decrease in the number of condoms distributed this may be related to the overall reduction in contacts with target populations.
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<td>Conclusion</td>
<td>There is a slight decrease in total number of contacts and a shift in populations reached.

Immediately following intervention the majority of respondents report their knowledge about HIV has increased. The sustainability of this knowledge cannot be determined.

Access to safe sex resources has decreased since 2007/08.
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4.4 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.	
Indicators	• Increased knowledge

- Availability of harm reduction supplies
- Access to service
- Involved in program planning and delivery

2009-2010 results (2008/2009)

Clients served

Harm reduction activities focus on providing services to people who use drugs. The total number of clients served has increased but the number of client contacts have decreased over the last year. Seven agencies report distribution of needles.

PWUD	08/09	09/10
# clients served	9,399	11,319
# of client contacts	50,585	44,217
# of needles distributed	1112,883	1280,690

In 2007/08 1124,413 needles were distributed.

Client feedback on harm reduction services

Over the last year, 60% (38%) of the ASOs reported the use of tools to gain feedback from harm reduction activities with people who use drugs. This resulted in 295 (237) completed tools.

Statement (n=295)	Always		Sometimes		Never	
	08/09	09/10	08/09	09/10	08/09	09/10
Services are available when needed	51	65	47	35	2	1
Can get supplies to have safe sex	66	82	32	17	2	1
Can get supplies to use safely	50	73	47	24	3	3

Client predicted future behaviour

About ¾ of respondents indicated they will make safer decision in the future as compared to before having contact with the service provider.

Statement (n=290) (no data from 08/09)	Yes	No	Don't Know	Don't care	Don't have sex/use
Make safer decision when to use, than before started using services	75	10	7	1	8
Make safer decisions when having sex, than before starting using services	71	14	6	1	8

Change over time

The total number of clients served over the last year has increased by 20%.

The total number of contacts has decreased by 13%.

	The frequency ratio of service to clients has decreased from 5 times/client to 4 times/client served. This may reflect that each contact is more successful in meeting the client's needs. Seven agencies distribute needles. Together they have increased the number of needles distributed by 1.5 % There is an increase in the proportion of ASOs that use a systematic way of receiving feedback from clients. However, this has resulted in fewer completed surveys. Even though ¾ of the clients indicated they will make safer decisions in the future based on the contact they have with the service providers, this type of prediction is poorly supported in the literature as being reliable.
Conclusion	More clients are being served, but this has resulted in fewer contacts overall. This change in service intensity may be reflected in the survey results where about half of the respondents indicate that services are "always" available when needed. Whereas 70-80% indicated that supplies are "always" available when needed. More needles are being provided at a range of locations. About ¾ of respondents indicated they will make safer decision in the future as compared to before having contact with the service provider.

4.5 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.	
Indicators:	• Volunteer recruitment and contributions • Staff retention • Staff training
2009-2010 results (2008/2009)	*Volunteer contributions* Volunteer contributions are reported by all ASOs. There have been slight fluctuations over the past three years in the total numbers of volunteers reported, with the highest level reported in the last six months.

Year	April -Sept	Oct- March
07/08	602	545
08/09	524	534
09/10	664	695

The total number of hours contributed was 19,597 (12,972) hours

in the past years and 7,017 hours in 2007/08. This equate to over 10 FTE provided by volunteers in the past year.

A range of activities are provided by volunteers. Types of activities provided by the volunteers within the ASOs are reported below by percentage of agency reporting.

Activity	08/09 % of agencies	09/10 % of agencies
Administration	54	60
Advisory role	77	84
Support/assistance for PLWH	46	40
Prevention/education	77	84
Fundraising	61	72
Special events	85	84
Peer Support	77	80
Other	46	28

All of the agencies reported that they had recruited new volunteers within each of the reporting periods. In total 341 new volunteers were recruited over the past year.

Staff

The staff components have increased over the past three years and it appears to now have stabilized slightly above 100 staff.

Year	April -Sept	Oct- March
07/08	-	39.6 (total yr)
08/09	103	129
09/10	121	110

Of the total staff complement about 60% (48%) are reported being fulltime.

Among all staff positions 51% (33%) have been in their positions longer than 2 years.

Volunteer training

In total, 91 (72, 12) training sessions were provided to 325 (246) volunteers. Most of the volunteers provided feedback on the workshops.

Statement (N=83)	Strongly agree	Agree	Neither	Disagree	Strongly disagree
I will be able to use the information I received in my work	39	54	8	0	0
I have learned new skills that will help me in my work	47	46	7	0	0

The workshop provided me with the opportunity to network with my peers	67	25	0	0	

Staff Training

Staff training sessions were provided 377 (383, 145) times to 751 (892) staff. Most of the participants provided feedback on the sessions.

Statement (N=329)	Strongly agree	Agree	Neither	Disagree	Strongly disagree
I will be able to use the information I received in my work	50	41	7	1	0
I have learned new skills that will help me in my work	37	41	15	3	1
The workshop provided me with the opportunity to network with my peers	42	38	14	3	1

Change over time

Volunteers play an active role in ASO across Alberta. The scope and magnitude of involvement have increased over the past year.

Volunteers are involved in many different roles, the most common being special events, peer support, education and advisory roles. The total number of hours contributed has more than doubled over three years.

ASOs are constantly recruiting new volunteers.

13 % of volunteers participated in training over the past year. The most valuable outcome according to participants was the opportunity to network with peers.

Staff components have stabilized to slightly over 100 people.

Most of these are now fulltime positions.

Staffing structure is becoming more stable with half of the staff having been in their position longer than 2 years.

Conclusion

The staffing structure shows increased stability.

	Staff and volunteers receive training and gained information and new skills from this training. Volunteers are involved in all aspect of the ASOs.

4.6 Partnerships*:* Expanded reach of HIV related services and support.	
Indicators:	• Increase in new partnership • Increased # of organizations worked with • Increase in type of primary area reached
2009-2010 results (2008/2009)	*Partnerships* Partnerships are established by the ASO at the community level as well as across the province. This is one vehicle to strengthening service delivery and ensuring that greater proportion of the target population can be reach by reducing barriers and increasing the buy-in to service delivery.

	07/08	**08/09**	**09/10**
Total number of partnerships reported	125	216	209
Total new partnerships	-	-	81
Type of organization:			
Private sector	10%	17%	11%
Public sector	25%	29%	31%
NGO	65%	50%	50%
Other	-	5%	8%
Primary area of focus for partner organization:			
Health	56%	52%	35%
Education	4%	8%	19%
Social Services	20%	13%	11%
Aboriginal	-	2%	7%
Housing	2%	5%	5%
Justice	6%	6%	4%
Academia/research	-	1%	1%
Recreation	-	5%	2%
Environment	-	-	1%
Industry	-	3%	2%
Transportation	-	-	1%
Other	12%	4%	13%

A review of the partnering organizations identified three partnerships that suggested a focus on new Canadians from countries where HIV is endemic. This implies that less than 1% of partnerships have a strategic focus on this target population.

The results of the partnerships are difficult to assess since the information provided is broad in nature and does not speak to specific outcomes. However, the most frequently stated type of result of the partnerships is increased access for the organization to provide programs and education sessions. The results can be

seen below:

Type of outcome reported	% agencies reporting outcome 2009/2010
Increased access for ASOs to deliver programs, education sessions, workshops, attending fairs, etc	41%
Improved capacity to reach clients and provide care	30%
Maintaining relationships	16%
Increased awareness in the community	8%
Research initiatives	2%
Advocacy for target population	2%

Change over time	The number of partnerships has nearly doubled since 2007. The total number of partnerships established or maintained remains the same over the past two years Over the last year 81 new partnerships were reported as having been established. Since the total number of partnerships remained stable this means that a similar number (81) partnership ceased to exist. Most of the ceased partnerships appeared to be time limited in nature. NGO constitutes half of all the partnerships. Many of these reflect work done at the community level. The diversity of focus areas have increased over the past three years. Health was reported as being the focus of 50% of the partnerships in the previous two year. In 2009-2010 about a third of the partnerships had this focus. Aboriginal partnerships show an increase from 2% to 5%. This may be partly due to coding by the evaluator. To ensure that Aboriginal partnerships were captured any reports that included Aboriginal focus (more than one response) in this category was coded as being Aboriginal in focus. It is unknown to what degree the partnership's primary focus is Aboriginal in nature. Partnerships strategically focusing on new Canadians from countries where HIV is endemic appear to be less that 1%. Partnership outcomes are focused primarily on improving ASOs access to target population for improved service delivery and to provide education and programs to various populations.
Conclusion	The number of partnerships remains the same from previous year.

	There is a turnover of about 80 partnerships over the last year. There is an increase in reach and diversity of partnerships over the last three years. Few partnerships focus on Aboriginal populations and new Canadians from countries where HIV is endemic. Partnership outcomes are improved access for the ASO to provide programs and services.

4.7 Involvement: Target populations' involvement in program development, delivery, evaluation and governance.	
Indicators:	• High risk populations level and type of involvement • PLWH level and type of involvement • Practitioners level and type of involvement
2009-2010 results (2008/2009)	*Level of involvement* Most ASOs involve all the target populations in some aspect of the management and delivery of programs and services.

% of agencies reporting involvement

		High risk population		PLWH		P/P/SP	
		08/09	09/10	08/09	09/10	08/09	09/10
Not applicable. Target pop not involved.		8	0	31	20	0	4
Given informal opportunities		77	84	70	68	100	92
Given formal opportunities		85	80	77	60	70	76
Volunteer role in delivery of programs		92	96	54	56	85	72
Directly involved in providing advice		70	80	54	56	85	84
% of agency decision makers are from the target pop	> 25%	54	80	61	72	23	24
	25-50%	38	12	15	4	15	20
	> 50%	0	0	0	8	70	48
Employed by organization		54	56	15	20	46	28
Other		8	8	8	8	0	4

Change over time	Organizations involve the target populations in most aspects of their program planning, development, delivery and governance. For both years the most frequently noted involvement was for high risk populations in a "volunteer role in delivery of programs". High risk populations are more involved than PLWH.

	Decision makers tend in general to come from the professional/ provider perspective whereas employment is more common among high risk populations.
Conclusion	Target populations are involved in all aspects of program development, delivery and governance.

4.8 Policy and Practice*:* Changes to policy and practice within other organizations and sectors.

Indicators:

- # of changes
- Type of changes
- Type of organizations
- Contribution factors

2009-2010 results (2008/2009)

Approaches used

Different approaches were used by ASO to improve other organizations' and professions' capacity to address HIV.

Approach	Used by % of agencies	
	08/09	09/10
Training	100	85
Developed resources/tools	69	54
New programs	77	54
Other	77	61

More than half of the respondents indicated that new or additional programs have been developed in their community as a result of ACHF funded activities. It is unclear if these are new programs within other organizations resulting from the work of the ASOs or if the responding ASO initiated new programs themselves.

Intention to influence policy

Actions taken to intentionally influence and/or develop community capacity were noted by 60% of the ASOs. The most common type of work focused on:

- Housing and homelessness
- Health service provisions border of service delivery
- Employment status for those caring for loved ones
- Harm reduction policy for Alberta

Actions	Used by % of agencies	
	08/09	09/10
Developed working relationship with representatives who can provide access to policy process	70	67
Meeting with policy makers	46	87
Participated in policy development process with policy makers	38	27
Presented briefs or positions papers	23	13
Prepared and distributed a policy research report	8	13
Other	31	33

	Successfully influencing policy 40% of respondents indicated they have been successful in influencing policy. Most of the reported changes were service related rather than policy related. However, two examples of policy changes resulting from ASOs work were reported: • Salvation Army adapted a Harm Reduction Framework when working with their clients. The most evident result of this was the introduction of safe disposal boxes. • Oil industry camps incorporated a Harm Reduction and Sexual Health program for its workers. This is carried out with the support of resources from the ASO. *Monitored changes*: 76% report that they have monitored changes in the target populations' access to health services. The type of monitoring and changed noted were: • Tracking client feedback on service access and delivery • Tracking access to social support that influences health determinants. • Inequitable service delivery and responding with new approaches.
Change over time	ASOs have shifted their work from focusing on establishing working relationships with policy makers to meeting directly with policy makers in order to influence policy changes in the province. Close to half of the ASOs indicated they have been successful in influencing policy. However, most of these are service delivery related rather than policy related. Two examples of policy changes were reported. Most of the ASOs also actively monitor the target populations' access to services in order to be able to respond if needed.
Conclusion	There appears to be a shift away from influencing policy and practice within other organizations through education and partnerships to a more direct approach of meeting with policy makers. There is active monitoring by ASOs of target populations access to services.

5. Overall Conclusions

Overall, based on the secondary data the following trends support that short term outcomes in the Provincial Evaluation Framework are being met:

- ASO are increasingly reaching other sectors by sharing resources developed for the HIV/AIDS target population and providing education training sessions for service providers.

- ASOs have intensified their work with policy makers. There appears to be a shift away from influencing policy and practice within other organizations through education and partnerships to a more direct approach of meeting with policy makers

- Target populations are involved in all aspect of program development, delivery and governance. Volunteers are involved in all aspect of the ASOs.

- There is an increase in reach and diversity of partnerships over the last three years.

- The staffing structure shows increased stability. Staff and volunteers receive training and gain new skills from this training.

- Clients living with HIV/AIDS have access to services and they are satisfied with the services they receive.

- Clients report increased knowledge of HIV related issues.

- ASOs are beginning to adopt a systematic approach of gauging results from their education/workshop sessions including active monitoring of target populations' access to services.

Areas that appear to have challenges:

Overall, based on the secondary data the following trends do not support that short term outcomes in the Provincial Evaluation Framework are being met:

- There is a decrease in total number of contacts made with target populations and a shift in type of populations reached. There are also indications that there is a need to define "those most at risk populations".

- With an increasing population in Alberta of people from countries where HIV is endemic ASOs need to reach greater proportions of this population. There is little evidence that this population is being targeted.

- Access to safer sex resources has decreased over the past three years.

- There is a 13% decrease in the total number of contacts made within the harm reduction programs.

- There is a 5% reduction in number of contacts with PLWH.

- ASOs report a 15 times increase in contacts made with the general population over the past year. This has been carried out through multiple avenues such as presentations, media coverage and sharing information with other organizations. Considering the limited resources available to ASOs to what degree should ASOs target their effort within this population?

6.0 Recommendations

Based on the trends reported above the following recommendations are made:

6.1 Define target populations and develop strategies to reach them

With limited resources it is imperative that ASOs are strategic and explicit in their interventions. To facilitate this ASOs should together with funders and based on available research clearly define who the target populations are within Alberta. The populations '*most-at-risk'* should be clearly define and resources should be allocated to these. These definitions should be specific to include the type of sub-populations, population characteristics, access points, any specific defining characteristics such as behaviours, gender, age, location, patterns, types of risks, etc.

Once the populations have been clearly defined and agreed upon, specific strategies should be developed by each ASO in relation to the population they are targeting. This should be based on excepted best practices and strategies that are known to be effective in reaching these populations.

6.2 Improve data collection

The overall roll-up of reported outcomes for the 13 ASOs in Alberta proved to be a complex and difficult activity partly due to irregularities with the secondary data. In order to enhance the confidence in the data and to support the ongoing collection of valid data the following should be considered:

- Define and distinguish between evaluation data needs and monitoring needs.
- Correlate data requirements to activities that are known to lead to desired results (Theory of change).
- Reduce the volume of reporting requirements and focus on improving data quality, consistency and validity.
- Consider yearly evaluation reports supported by more frequent monitoring requirements for ASOs who would benefit from this type of support.
- Every program activity does not need to be evaluated each year. When results are based on sound Theory of Change – tracking key outputs can ensure that the program continues to deliver services based on best practices and known result agents.

- Establish pre-post measures of intervention instead of recall measures.
- In addition to training of ASO staff in completing data collection tools, include specific instructions in the tool.
- Work with ASO in defining hierarchy of data needs. This should assist in clarifying *'need to know versus nice to know'* data sets.
- Consider how non-traditional methods of reporting can be incorporated into the evaluation structure such as staff journaling and structured observations.
- Encourage increased and consistent use of tools that capture clients' changes in knowledge and change in behaviour.

6.3 Use evaluation to impact practice

The ASOs invest extensive resources in completing the semiannual submissions; however, this work does not appear to be used by the organizations internally. Evaluation is about knowledge generating and should support agencies in their planning and strategic activities. It should provide findings that are relevant, timely and insightful. Evaluations should not only address questions related to *"what and to what degree*" but more so answer the questions related to "*how and why something resulted*".

ASOS must begin in a constructive way to use the data they collect within their organizations. They must begin seeing the value of evaluative work and data. This can only be done if they define the data sets that are important and helpful to them and their organization. This should be done jointly by all the ASOs and form the basis for the new improved data collection structure.

Appendix A

Evaluation Roll-up Matrix

Introduction:

The following work plan was developed based on ACCH background material, ASO October 2009 reports, and discussion with the Executive Director. It is developed with the following principles in mind:

- **Outcomes based:** The work will be focused on capturing the outcomes that have been achieved over the last year (not outputs).
- **Utility:** The evaluation will be utilization focused, to allow easy use and with targeted users in mind.
- **Constraints and limitations**: The evaluation will be designed to increase (to the greatest degree possible) data confidence (triangulation). The evaluation will be completed within the resources and time limitations that exist to optimize products.
- **No additional burden**: The evaluation work will be completed using existing data as much as possible, striving constantly to reduce additional burden to ASOs.
- **Ethical**: The evaluation will be conducted in an ethical manner using ARECCI framework, recognizing in particular issues related to confidentiality, privacy, data sources, methods and burden.

Annual Evaluation of ACHF's funded operations - to what degree are the short term outcomes being achieved				
Areas of Inquiry	**Indicators** (stemming from outcome statements)	**Data sources** Harmonized Outcomes Measurement for Organizational Reporting	**Gaps/missing data**	**Notes**
Prevention: Change in knowledge and behavior of high risk populations	• Increased knowledge • Access to safe sex resources • Organizational partnerships established	Q 40, 41 – scope Q 46 Q 44 Q 87		
Health Promotion: PLWH have increased capacity to lead healthier and safer lives	• Increased knowledge • Access to support • Access to 24/7 intensive and end-of-life care	Q 29, Q 28 – scope Q 37 Q 36 Q 37		
Strengthening Community Based Organizations : Strengthen organizational capacity	• # of staff > 2yrs • Reason for leaving • Received training	Q 66, Q67 Q68 Q 75, 76, 77,80 Q60, 61, 62, 63, 64,	Demonstrate capacity for program planning,	

		and 79	implementation, evaluation and reporting.	
Harm Reduction: Person using drugs have increased capacity to lead healthier and safer lives	• Increased knowledge • Availability of harm reduction supplies • Access to service • Involved in program planning and delivery	Q 49,50 – scope Q 55,56 Q 57 Q 57		
Partnerships: Expanded reach of HIV related services and support	• Increase in new partnership • Increased # of organizations worked with • Increase in type of primary area reached	Q 87 Q 87 Q 87		
Involvement: Target populations' involvement in program development, delivery, evaluation and governance.	• High risk populations level and type of involvement • PLWH level and type of involvement • Practitioners level and type of involvement	Q 83 Q 83 Q 83		
Policy and Practice: Changes to policy and practice within other orgninazations and sectors.	• # o changes • Type of changes • Type of organizations • Contribution factors	Q, 13, 14, 15, 16, 17, 18, 19, 22, 23	• # of changes • type of changes • type of org • contribution factors	
Creating Supportive Environments: Community has increased knowledge of HIV and related issues and increased support	• Access to information • Increased knowledge	Q 3, Q7, Q9 Q10 Q 24, 25 Q 88, Q89	• 'Up-to-date' information • Awareness	
Final deliverable: An outcome based synopsis based on the ACHF Evaluation Framework. A brief report that captures the progression towards stated outcomes during year 2009-2010.				

Roll-up Evaluation of ACCH's Operation 2007 -2010 and Moving Forward

Areas on Inquiry	Indicators	Data sources	Notes
In what areas have ACHF had the most success? And Why?	Progression over time related to specific 8 target areas.	Evaluation reports from 2007/08 2008/09 2009/10 Interview with ACCH Board Interview of Executive Director ACCH Interview with funders	
In what areas have ACHF had the least success in meetings stated outcomes?	Lack of movement toward stated outcome.		
What areas have acted as barriers to success?	Reported or suggested barriers by ASO. Reported or suggested barriers by Board Reported or suggested barriers by Funders. Reported or suggested barriers by Executive Director		
What areas have facilitated success?	Reported or suggested facilitators by ASO. Reported or suggested facilitators by Board Reported or suggested facilitators by Funders. Reported or suggested facilitators by Executive Director		
How has ACCH incorporated formative feedback?	Actions initiated based on recommendations from 2007-2010. Results of these actions. Recommendations not acted on, why and potential impact.		
How does ACCH 2010-2013 strategic plan align with the learnings from 2007-2010	What elements in the strategic plan are based on previous learning? How does the strategic plan support and move the ACHF in the desired direction? What changes/additions may be considered?		

Final deliverable: High level feedback and direction for ACCH to move forward to fulfill its mandate and provide the support and structure required by ASOs.