
ACHF Evaluation 2008-2009

Assessing the
Outcomes

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Ltd.
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List of Acronyms

Acronym	Complete Wording
ABV	AIDS Bow Valley
ACCH	Alberta Community Council on HIV
ACHF	Alberta Community HIV Fund
AIDS	Acquired Immune Deficiency Syndrome
ASO	AIDS Service Organization
CAANS	Central Alberta AIDS Network Society
CIHR	Canadian Institutes for Health Research
ED	Executive Director
GLBTQ	Gay, Lesbian, Bi-sexual, Transgendered, Questioning
HSSA	HIV Society of Southeastern Alberta
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HWY	HIV West Yellowhead
IDU	Injection Drug User
LHC	Lethbridge HIV Connection
MLA	Member of Legislative Assembly (Alberta)
MP	Member of Parliament
MSM	Men who have Sex with Men
NGO	Non-Government Organization
NPNU	Non-Prescription Needle Use
PLWH	People Living With HIV
PLWHA	People Living With HIV/AIDS
P/P/SP	Practitioners/Professionals/Service Providers
PWUD	People Who Use Drugs
PWUID	People Who Use Injection Drugs
STI	Sexually Transmitted Infection
WHBAS	Wood Buffalo HIV & AIDS Society
YMCA	Young Men's Christian Association

Executive Summary

Introduction and Methodology

The Alberta Community HIV Fund (ACHF) is a joint community/provincial/federal fund disbursement model providing operational funding. The ACHF Provincial Evaluation Framework was developed to account for the collective results of HIV/AIDS work funded through the Alberta Community HIV Fund. The Evaluation Framework was revised in 2008 and includes eleven evaluation questions, as well as 13 short term outcomes and 14 intermediate outcomes. The purpose of the 2008-2009 ACHF Evaluation is to analyse the operational output data and program results, interpret the data in relation to the evaluation questions, and analyse the extent to which ACHF short term and intermediate outcomes have been achieved. A number of limitations with the data are noted in the report.

Results

Some evaluation questions are analyzed looking at the results related to only one outcome. Others, however, require examination of multiple outcomes. In these circumstances, an additional subheading is added to summarize all the outcome results linked to the evaluation question.

Evaluation Question 1: Are the short term outcomes in the Provincial Evaluation Framework being achieved?

High risk populations are more knowledgeable about HIV/AIDS including transmission, prevention and risk behaviour.

Agencies provided education and awareness sessions to populations at high risk for HIV (prisoners, youth/students, aboriginal people, women, MSM/gay men/GLBTQ, people from countries where HIV is endemic, and at-risk individuals), totaling 355 sessions to 19,706 individuals. There were 184 materials available for high risk populations, with over 24,000 copies of these materials distributed. Surveys demonstrated increased knowledge among high risk populations (n=3,211). There is evidence that high risk populations are more knowledgeable about HIV/AIDS, including transmission, prevention and risk behaviour.

High risk populations have access to safer sex resources (condoms, etc.), prevention messaging and social support.

High risk populations were provided prevention messaging through outreach on 1,035 occasions, providing 32,770 contacts with high risk individuals. High risk populations were provided support services on at least 4,519 occasions, providing 11,871 contacts with high risk populations. Agencies provided education and awareness sessions to populations at high risk for HIV, providing 355 sessions to 19,706 individuals. There were 184 materials available for high risk populations, with over 24,000 copies of these materials distributed. ASOs distributed at least 211,238 condoms throughout 2008/09. There is evidence that high risk populations have access to safer sex resources, prevention messaging and social support.

ASOs have partnerships for HIV prevention initiatives directed at high risk populations.

There is evidence that ASOs have partnerships for HIV prevention initiatives aimed at high risk populations. Most of the partnerships with health and social service agencies in the not-for-profit sector are partnerships that enhance outreach, by providing preventive outreach services to high risk populations at locations such as addictions treatment facilities, shelters, and youth agencies.

PLWH and those affected by HIV/AIDS are more knowledgeable about HIV related issues.

There were six workshops provided to people living with HIV/AIDS (PLWH), resulting in 66 contacts, in addition to three displays reaching 52 people living with HIV. There were 58 outreach occasions providing 330 contacts with people living with HIV, and 1,877 occasions of support provided to PLWH, involving 3,904 contacts with individuals. There were 96 outreach occasions making 96 contacts with those affected by HIV/AIDS, as well as 22 support occasions involving 22 contacts with those affected by HIV/AIDS. There were 61 resource materials targeted to PLWH and those affected, with at least 1,227 copies distributed. Results from surveys with PLWH (n=56) and those affected (n=16) demonstrated increased knowledge of HIV related issues. There is evidence that people living with HIV and those affected are more knowledgeable about HIV related issues.

PLWH and those affected by HIV/AIDS have access to appropriate and non-judgmental supports in ASOs, including other PLWH.

Agencies reported serving 1,063 health promotion program clients during the first reporting period and 1,062 clients during the second reporting period. Based upon the number of contacts that agencies reported with Health Promotion program clients (9,912), it is clear that they have access to supports in ASOs. Seven agencies offered peer support programming or group support through social activities and events. Agencies reported survey results (n=59) in which 97% of clients strongly agreed or agreed that ASO staff members treated them with dignity and respect and 96% of clients strongly agreed or agreed that the services provided to them are useful and appropriate to their needs. Results from surveys (n=12) conducted with those affected indicated that 100% of respondents strongly agreed that the agency provided them and their loved one with non-judgmental supports. There is evidence that PLWH and those affected by HIV/AIDS have access to appropriate and non-judgmental supports in ASOs, including other PLWH.

PLWH have access to 24/7 intensive care and end-of-life care.

Through the two assisted living organizations, there is evidence that PLWH have access to 24/7 intensive care and end-of-life care. Four people in each six month period were provided intensive care and five individuals who passed away received end of life care. It should be noted that ACHF funds 18 beds in the assisted living facilities, and some residents are in transitional care, meaning that they are being supported towards independent living and are not in intensive or end-of-life care. There will only ever be a small sample size for this outcome.

Individuals have increased knowledge of and access to harm reduction services and information.

Needle exchange programs offer services directly related to needle exchange, as well as related services such as information and referral, health-related services, support services and outreach. There were 2,600 outreach occasions serving people who use drugs that were not directly related to needle exchange, reaching 20,070 individuals, and 158 support occasions with 3,330 contacts. The harm reduction programs reported 50,585 contacts with harm reduction program clients overall (including exchange-related contacts). The needle exchange programs distributed 1,112,883 needles in 2008/09, in addition to other supplies such as water, citric, crack kits, mouthpieces, piercing kits, cookers and pipes. In addition, 50 resource materials were available for people who use drugs, with 52,034 copies of

materials distributed. Survey results demonstrated that people who use drugs can access the supplies they need to have sex and use drugs safely (n=237). There is evidence that individuals have access to harm reduction supplies and information.

There is appropriate availability of harm reduction supplies.

Harm reduction supplies are accessible through six agencies which offer supplies through at least 43 different locations. The number of locations through which supplies are available increased from 26 locations 2007/08 to 43 locations in 2008/09. There is evidence of appropriate availability of harm reduction supplies.

Community members and partners have up-to-date information on HIV/AIDS and related issues.

Community members and partners were provided up-to-date information through a variety of means. Agencies received media coverage on a reported 473 occasions, and provided 414 workshops, presentations, displays, conferences and other events to the general public and practitioners, professionals, and service providers. These events reached at least 29,157 individuals. In addition, 296 resources for community members and practitioners/professionals/service providers were available, with over 56,000 copies distributed. Twelve agencies hosted and updated websites that provide information to community and partners (146 updates). There is evidence that community members and partners have up-to-date information on HIV/AIDS and related issues.

Community members and partners have awareness & knowledge of HIV/AIDS.

In addition to the workshops and materials previously described, the 245 ride-alongs were another means of creating increased awareness and knowledge of HIV/AIDS and related issues. The number of students (156) and number of volunteers (542/534 per six month period) are additional measures of community member awareness of HIV/AIDS. Surveys conducted with practitioners/professionals/service providers demonstrated increased knowledge after a workshop (n=324). There is evidence that community members and partners have awareness and knowledge of HIV/AIDS.

ASOs demonstrate capacity for program planning, implementation, evaluation and reporting.

There is evidence that agencies are collecting more data, conducting evaluations, using that data to revise their programs, engaging in community-based research projects and providing more outcome measurement. Thirteen agencies (up from seven) provided survey results to measure outcomes with various populations. The number of agencies (11) reporting a variety of planning and evaluation documents is further evidence of program planning and implementation capacity. Reporting of output and outcome data increased from 2007/08, as well as increased from the first report to the second reports in 2008/09. ASOs have demonstrated capacity for program planning, implementation, evaluation and reporting.

Staff retention is increased.

Forty-three of the 129 total staff reported on the second reports had been retained for more than 2 years. Because this is the first year of data for this output, this must be considered baseline data, so there is not yet evidence whether staff retention increased. There is no evidence for this outcome.

Staff and volunteers are provided the training necessary to offer quality services.

Staff and volunteers were offered 455 training opportunities with a total attendance of 1,138. Training was provided on topics related to agency management, client-related issues, population-specific issues, HIV/HCV/STI, harm reduction, and other organizations. Agencies provided outcome survey results regarding the trainings which demonstrated that the training provided attendees information, skills and

networking (N=414). There is evidence that staff and volunteers are provided the training necessary to offer quality services.

Analysis of Evaluation Question 1: *Are the short term outcomes in the Provincial Evaluation Framework being achieved?*

As detailed above, there is evidence that 12 of the 13 short term outcomes in the ACHF Evaluation Framework were achieved.

Evaluation Question 2: *What is the evidence of changes in the knowledge and behaviour of reached high risk populations?*

Reached populations make informed and healthy choices around sexual health and risk behaviours.

There are a number of outputs that can be examined here, in addition to some survey results. One healthy choice demonstrated by reached populations is the number of tests; two agencies reported conducting 2,278 tests in 2008/09. Seeking referrals is another indicator of healthy choices, and agencies reported providing 3,982 referrals of high risk individuals to other health and social services. In a sample of 1,065 high risk individuals, 81% indicated “yes” to the question: “If I were going to have sex I would talk to my partner about using a condom.” Based on the outputs and survey results, there is evidence of reached populations making informed and healthy choices around sexual health and risk behaviours. There is also evidence of changes in the knowledge and behaviour of reached high risk populations.

Evaluation Question 3: *What is the evidence that PLWH have increased capacity to lead healthier and safer lives?*

PLWH access services outside of ASOs (i.e. Medical and social services).

Agencies supported PLWH to access services outside of ASOs by providing 7,616 referrals of health promotion program clients to health and community supports in other agencies. Agencies reported survey results related to this outcome (n=62) in which 95% of respondents strongly agreed or agreed that “Because of the Agency support, I feel I am able to get the health services I need.” There is evidence that PLWH access services outside of ASOs.

PLWH and those affected are satisfied with the services provided by ASOs.

Agencies provided survey results (n=59) in which 97% strongly agreed or agreed that they are satisfied with the quality of services received at the agency. While the surveys conducted with those affected did not directly ask about satisfaction, the results presented previously in which 100% of respondents agreed that the agency provides them and their loved one with non-judgmental supports can be taken as a proxy indicator of satisfaction. There is evidence that PLWH and those affected are satisfied with the services provided by ASOs.

PLWH are actively involved in activities that enhance and maintain their health.

Agencies reported involvement of PLWH in organizing nutrition programs, organizing and attending conferences such as Alberta’s Positive Voice Conference and the Alberta Harm Reduction Conference, providing presentations, volunteering at weekly drop-in programs, taking on roles as resident representatives on boards and committees, and assisting with peer support programs. It can also be said

that residents and outreach clients of assisted living facilities who are in transitional care (10/7 per six month period) are involved in activities to enhance and maintain their health as they are supported towards the goal of healthy, independent living. Agencies reported the following survey results related to this outcome (n=62): 86% of PLWH strongly agreed or agreed that they are invited to participate in decisions about services they receive; 70% strongly agreed or agreed that staff members supported them to be in contact with family and friends. There is evidence that PLWH are actively involved in activities that enhance and maintain their health.

Analysis of Evaluation Question 3: What is the evidence that PLWH have increased capacity to lead healthier and safer lives?

Together, the above three outcomes provide evidence that PLWH have increased capacity to lead healthier and safer lives.

Evaluation Question 4: What is the evidence that people who use drugs have increased capacity to lead healthier and safer lives?

People who use drugs access the services and support they need and are making safer decisions.

There is a variety of data supporting the fact that people who use drugs access the services and support they need. There were 2,600 outreach occasions serving PWUD that were not directly related to needle exchange, reaching 20,070 individuals, and 158 support occasions with 3,330 contacts. The harm reduction programs reported 50,585 contacts with harm reduction program clients overall (including exchange-related contacts). The number of tests provided (2,278) is another indicator of safer decision making. There were 1,112,883 needles reported distributed in 2008/09, which is a further indicator of safer decision making. Agencies reported having used the Harm Reduction Client Survey (n=237) in which 77% said they make safer decisions when using drugs and 71% said they make safer decisions when having sex than before they started using the needle exchange program. There is evidence that people who use drugs accessed the services and support they need and are making safer decisions, and there is evidence that people who use drugs have increased capacity to lead healthier and safer lives.

Evaluation Question 5: What is the evidence that the community has increased knowledge of HIV and related issues, as well as increased support for PLWH, people who use drugs and high risk populations?

The commitment and capacity of other organizations and sectors to address HIV is increased.

ACHF funded organizations engaged on a wide variety of community action issues in order to influence the commitment and capacity of other organizations and sectors to address HIV. When engaging on issues, ASOs used a variety of methods to improve other organizations' and professions' capacities to address HIV: partnerships; training of professionals; offering student practicum placements; preparing resources and tools; needle exchange program van ride-alongs, and; activities to influence policy. These methods were used 1,146 times to increase the commitment and capacity of other organizations and sectors to address HIV.

A key measure of the increased commitment of other organizations and sectors is the number of partnerships. In 2007/08, there were 125 collaborative partnerships reported by ACHF funded agencies, while in 2008/09 there were 216 partnerships reported. There are additional partnerships noted in all sectors, but most notably health, education, housing, justice and industry. The number of new

partnerships is an indicator of increased commitment of other organizations and sectors to address HIV. Agencies reported survey results examining capacity to address HIV among the practitioners/ professionals/service providers who attended workshops. Of the sample of 223, 91% said that as a result of this workshop, they are more encouraged to talk about HIV testing with clients/peers and 89% said that they are more comfortable talking about safer sex practices with clients/peers. There is evidence of increased commitment and capacity of other organizations and sectors to address HIV. Regarding the evaluation question, there was evidence provided earlier of increased knowledge among practitioners/professionals/service providers about HIV and related issues, and evidence of increased commitment and capacity provides confirmation of increased support for PLWH, people who use drugs and high risk populations.

Evaluation Question 6: What is the evidence that the organizational capacities of ASOs have been enhanced through ACHF funding?

Diverse funding sources are attained.

Agencies reported a total of 119 other sources of funding, with a range between agencies of 1-73 sources (73 includes individual donors). In total, there was \$2,699,655 in other funding reported by the agencies, from nine types of funding sources. There is evidence that diverse funding sources have been attained by the ASOs.

ASOs provide evidence-based programming that is responsive to diversity, cultures, client feedback, evaluations, epidemiology and demographics of clients.

There is ample demonstration that ASOs are providing programming that is evidence-based and responsive. Agencies are serving and responding to many diverse target populations and cultures, and there is evidence that they are engaged in needs assessments and research projects to learn more about how best to work with individuals such as people from countries where HIV is endemic and Aboriginal people. Agencies are highly engaged in seeking and receiving feedback from clients in order to be responsive, and are conducting many forms of inquiry to seek input and evidence into their programming. They held discussions at ACCH meetings called “Best Practice Think Tanks” in which they reviewed literature on topics and discussed what it means for their service, and had skills building sessions learning about Hepatitis C and HIV co-infection, working with communities from countries where HIV is endemic, and prevention programs for transient populations, for example.

In addition to the above evidence provided through other outputs, ASOs were asked to respond directly to how they ensure that their agency provides programming that is responsive to diversity, cultures, client feedback, evaluations, epidemiology and demographics of clients. Some agencies responded in a summary format to this question, but others provided information particular to their responsiveness to each of these factors that provided additional evidence that this outcome is being achieved. One agency, for example, described 10 methods or tools used routinely to learn about what they are doing well and what they need to change. There is evidence that ASOs are providing evidence-based programming that is responsive to diversity, cultures, client feedback, evaluations, epidemiology and demographics of clients.

Analysis of Evaluation Question 6: *What is the evidence that the organizational capacities of ASOs have been enhanced through ACHF funding?*

The Alberta Community HIV Fund provides operational funding, which includes funding for management, overhead and administrative costs. In an era when many other funding opportunities are project based and, therefore, do not provide funding for ongoing operational expenses, the fact that ACHF supports these expenses then leads to the expected outcome that organizational capacities of funded organizations will be enhanced as they have stable funding to engage in various forms of organizational development. Enhanced organizational capacities are indicated by the attainment of the two outcomes above: attaining diverse funding sources and providing evidence-based programming that is responsive. With both outcomes related to this evaluation question being met, there is evidence that the organizational capacities of ASOs have been enhanced through ACHF funding.

Evaluation Question 7: *What is the evidence that collaborative partnerships resulted in an expanded reach of HIV related services and support?*

Partner organizations are working to prevent HIV with their clients.

The number of partnerships reported (216), the type of organizations involved and the descriptions of partnerships indicates clearly that there are partnerships focussed on HIV prevention. The evidence that partners are actively working on HIV prevention also comes from qualitative descriptions of the activities of and results from partnerships. There is evidence that partner organizations are working to prevent HIV with their clients.

An active network of NGOs, government agencies and other stakeholders collaborates to address harm reduction issues.

The Non-Prescription Needle Use Consortium (NPNU) is an alliance of approximately 35 representatives from government sectors and community agencies formed to reduce the harms associated with non-prescription needle use. Many of the ASOs participate in the NPNU and its various task groups. The NPNU is an active network of NGOs, government agencies and other stakeholders that collaborates to address harm reduction issues; this outcome is being achieved.

Harm reduction services are offered and accessed more widely through community venues (e.g. hospitals, pharmacies, prisons).

There are at least 43 locations for needle exchange offered by the six needle exchange programs funded through ACHF. Locations include pharmacies, mobile vans, other agencies and walking outreach. There is evidence that harm reduction services are offered and accessed more widely through community venues, as the number of locations increased from 2007/08 to 2008/09.

An increasing number and range of organizations and sectors are involved in addressing HIV.

One measure of the increasing number and range of sectors is the number of partnerships. In 2007/08, there were 125 collaborative partnerships reported by ACHF funded agencies. In 2008/09, there were 216 collaborative partnerships reported. There are additional partnerships noted in all areas of focus, but most notably in health, education, housing, justice and industry. There were also additional partnerships noted in all of the sectors inquired about (private, public, not-for-profit and other). There is an increasing number and range of organizations and sectors involved in addressing HIV.

Analysis of Evaluation Question 7: *What is the evidence that collaborative partnerships resulted in an expanded reach of HIV related services and support?*

All outcomes related to partnerships have been achieved. In addition to the evidence presented above specific to the outcomes, agencies estimated that other organizations provided 4,635 hours of loaned staff time to their agency. There is evidence that collaborative partnerships resulted in an expanded reach of HIV related services and support.

Evaluation Question 8: *How have target population members been involved in program development, delivery and evaluation, and in the governance of ASOs?*

Target population members are involved in program planning, evaluation, delivery and governance.

It is clear that target population members are involved in every agency, through informal and formal opportunities to express opinions about programming, volunteering in program delivery, sitting on committees and boards, and being employed by agencies. Target population members participate in their own groups and committees (user groups, Alberta Positive Voice Conference Planning), and play active roles in every agency. There is evidence that target population members are involved in program planning, evaluation, delivery and governance through a wide variety of activities.

Evaluation Question 9: *What is the evidence of changes to HIV-related policy and practice within other organizations and sectors?*

Policy and programs are adapted to meet the needs of PLWH, people who use drugs and those at risk.

ASOs provided 12 examples of new policies or practices within other organizations or sectors that impact HIV programming. There is evidence that policy and programs are adapted to meet the needs of PLWH, people who use drugs and those at risk, and there is evidence of changes to HIV-related policy and practice within other organizations and sectors.

Evaluation Question 10: *What lessons have we learned about the effectiveness of the services provided?*

Barriers

- Stigma and discrimination
- Safety
- Language
- Access to services
- Reaching Aboriginal populations

Approaches That Worked

- Assisting with basic needs and/or providing tangible benefits to clients
- Partnerships to reach populations

- Altering service hours, such as evening office hours, offering groups on weekends, evening workshops, evening outreach, finding partners to offer 24 hour access to needle exchange
- Providing services and supports that are respectful of cultural values
- Ongoing and repeated efforts to educate practitioners/professionals/service providers
- Outreach and support events and programs that reach target populations where they meet
- Responsiveness to input, adjusting programs, creating resources and addressing emerging populations.

Evaluation Question 11: What emerged as good practice for each of the five ACHF funding approaches?

The good practices are more general activities in each funding approach that were consistent among agencies and had evidence to support their effectiveness.

Crossing All Fund Approaches:

- Ongoing attention to evidence based practice, using service recipient feedback, routine data collection and other methods of evaluating needs and approaches
- Target population involvement (supports clients' progress, supports agency work, builds in feedback)
- Partnerships that are collaborative, engage other sectors and organizations, and build support for the work and for clients

Creating Supportive Environments:

- Training of practitioners/professionals/service providers on HIV, universal precautions, harm reduction, and stigma and discrimination
- Working with other community partners to co-host community events such as fundraisers, conferences and workshops
- Participating in committees and networks that raise awareness, build partnerships and impact policy and practice in other organizations and sectors

Health Promotion:

- Providing basic supports such as vouchers, food, clothing, bus tickets and transportation
- Ensuring agency services are accessible including, for example, evening and weekend support and support in hospitals and institutions

Harm Reduction:

- Outreach through vans, at other locations, on foot, with extended hours
- Attention to new or evolving transmission methods and prevention through additional supply distribution (e.g. crack pipes)

Prevention:

- Outreach to target populations through events and programs that engage populations where they meet (e.g. bar blitzes, bath houses, other agencies)
- Presentations to at risk populations, with surveys demonstrating increased knowledge and intended behaviour change
- Access to free safer sex supplies

Strengthening Community Based Organizations:

- Ongoing staff training, including basic training as well as training on emerging issues
- Use of volunteers to support the work and assist in creating supportive environments.

Recommendations

The ASOs are providing increasing evidence that they are meeting the outcomes of the Alberta Community HIV Fund. There is reliable evidence that the vast majority of outcomes in the ACHF Evaluation Framework have been achieved (26 of 27).

Recommendation: Given the rates of HIV infection among Aboriginal people, ASOs should ensure that there is Aboriginal focussed prevention programming being offered and reported upon.

Recommendation: ASOs need to identify a common method across the health promotion programs to capture contacts by type of services within the health promotion program specific to people living with HIV in order to differentiate as much as possible distinct services and contacts with PLWH.

Recommendation: Use the ACHF narrative report to focus ASO reporting regarding PLWH on the outcomes expected for that target population so agencies are prompted to consider other evidence (including stories) they can provide with respect to the outcomes.

Recommendation: Harm reduction programs should continue to innovate and respond to the needs of their target populations as they have historically.

Recommendation: ACCH should coordinate a review of the professions, practitioners and service providers who are in need of ongoing and repeated training to determine if action at the provincial level would be more effective in getting necessary HIV related information included in mandatory curriculums.

Recommendation: ACCH should continue to review and refine the Evaluation Framework and implementation strategies, including linkages, definitions, data collection tools and data collection methods on a yearly basis.

Recommendation: ACHF should review the narrative reporting form to align with any changes to the Evaluation Framework and to address the issues highlighted through this evaluation.

Introduction and Methodology

Background

Alberta Community HIV Fund

The Alberta Community HIV Fund (ACHF) is a joint community/provincial/federal fund disbursement model 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.¹ The Alberta Community HIV Fund is administered by the Alberta Community Council on HIV (ACCH): a provincial organization representing thirteen non-profit, community-based HIV and harm reduction organizations that come together to present a unified provincial voice on common HIV issues, provide training opportunities, and participate in community and organizational development.

The Alberta Community HIV Fund provides operational funding to community-based HIV organizations or harm reduction organizations to fund programming, key positions within an organization, and overhead and administrative costs. Operational funding is open to voluntary, non-profit, non-governmental organizations whose principal mandate is community-based HIV and/or Harm Reduction programming.

Fund Approaches

ACHF activities are organized according to the following 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 provide 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.

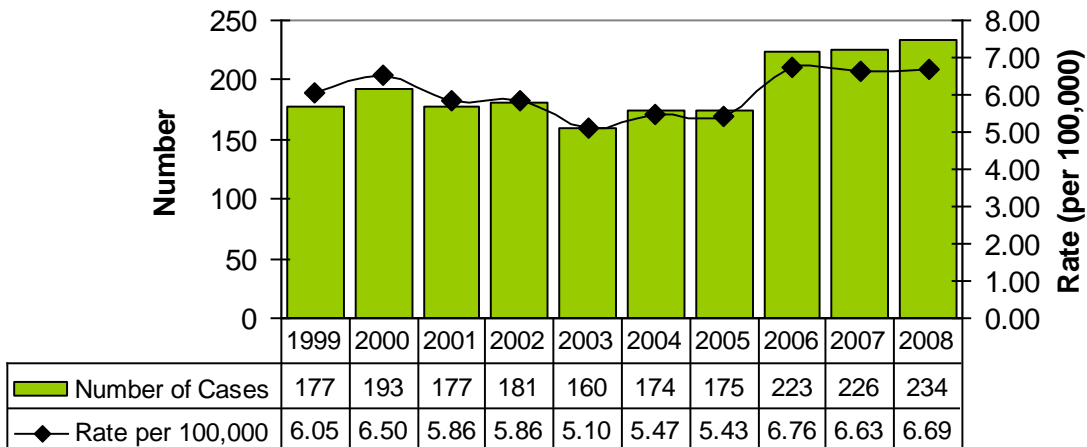
¹ Source: Alberta Community Council on HIV. What is the Alberta Community HIV Fund. Retrieved July 17, 2009, from http://www.acch.ca/alberta_community_hiv_fund.html

Provincial HIV Trends

It is important to examine the work of ACHF funded agencies within the context of HIV epidemiology in Alberta. All of the following epidemiological data was provided by Alberta Health and Wellness.² The figures presented have been imported directly from the source (including the original Figure numbers).

Figure 1. Number and Crude Rate of Newly Reported HIV Cases in Alberta by Year of Diagnosis

Number and Crude Rate of Newly Reported HIV Cases in Alberta by Year of Diagnosis. 1999-2008 (n=1,920)



Data provided by Alberta Health and Wellness regarding HIV surveillance show that the number of newly reported HIV cases in Alberta ranged from 160 to 234 cases per year between 1999-2008. The highest number of new cases per year was reported in 2008, with 234 new cases reported. While some of this increase is perhaps due to increased population, the rate per 100,000 population also increased in 2007 and 2008 in comparison to previous years. The total number of newly reported cases from 1998 to 2008 was 1,920 (males: n=1310, 68% male; females: n=610, 32% female). Most newly reported cases in 2008 were among those aged 30-39, followed by those aged 40-59 and then those aged 25-29.

Among newly diagnosed males, the largest exposure categories in 2008 were men who have sex with men (MSM), heterosexual endemic, and injection drug use (IDU)(Figure 2). Among newly diagnosed females, the largest exposure categories in 2008 were heterosexual endemic, heterosexual partner at risk, and IDU (Figure 3).

² Source: Kim Simmonds, Alberta Health & Wellness, Public Health Division. Data slides provided at ACCH meeting, June 25, 2009.

Figure 2. Proportion of Newly Reported HIV Cases by Exposure Category among Males by Year of Diagnosis

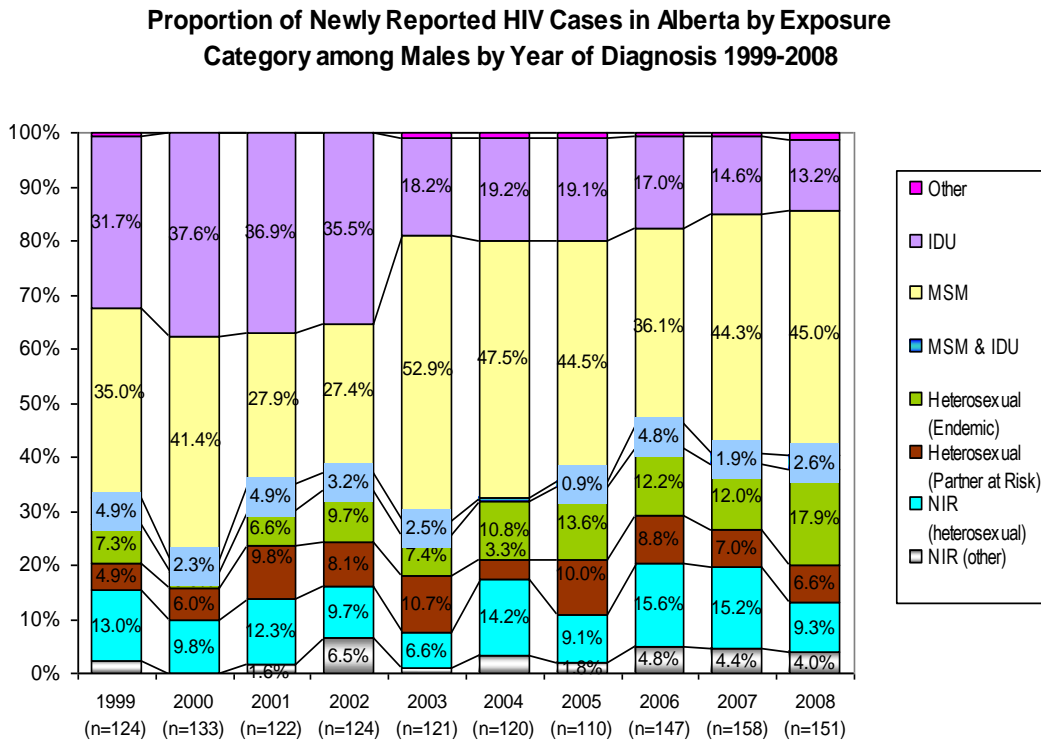
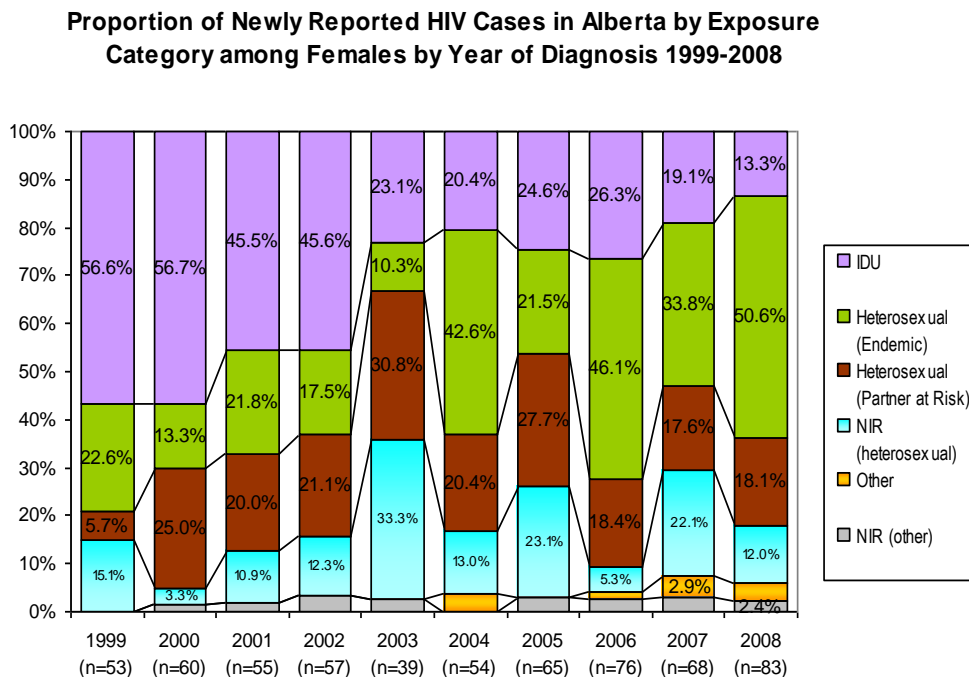


Figure 3. Proportion of Newly Reported HIV Cases by Exposure Category among Females by Year of Diagnosis



Looking at ethnicity among newly reported cases in 2008, 18% of newly reported cases were among Aboriginal people, 30% of newly reported cases were among African-Canadian people, and 39% of newly diagnosed cases were among Caucasian people.

Finally, Edmonton and Calgary regions continued to have the highest rates of newly reported cases.

Purpose of the Evaluation

The Provincial Evaluation Framework was developed in 2002 and revised in 2008 to account for the collective results of HIV/AIDS work funded through the Alberta Community HIV Fund. The Framework provides a lens for analysing the collective results of ACHF funded organizations. It was developed through a participatory process that included all ACHF operationally funded organizations. The Evaluation Framework includes eleven evaluation questions, as well as 13 short term and 14 intermediate outcomes.

The purpose of the 2008-2009 ACHF Evaluation is to analyse the operational output data and program results, interpret the data in relation to the evaluation questions, and analyse the extent to which ACHF short and intermediate term outcomes have been achieved. The evaluation focussed on the April 1, 2008 - March 31, 2009 timeframe.

Evaluation Questions

As mentioned previously, the Alberta Community HIV Fund has five fund approaches: Creating Supportive Environments; Health Promotion for PLWH; Prevention; Strengthening Community Based Organizations, and; Harm Reduction. The narrative reports from which this evaluation data was collected are organized according to the fund approaches. While this report will be organized by evaluation question, the fund approaches are an important method of organizing the work completed by ACHF funded organizations and therefore impact the way that the data was collected for the evaluation questions. Some of the evaluation questions cross all fund approaches, and some are population specific and take their data from only one fund approach. The chart below illustrates the correspondence of fund approaches and evaluation questions.

Table 1. Evaluation Questions and Corresponding Fund Approach

Evaluation Question	Creating Supportive Environments	Health Promotion for PLWH	Prevention	Strengthening Community Based Organizations	Harm Reduction
1. Are the short term outcomes in the Provincial Evaluation Framework being achieved?	✓	✓	✓	✓	✓
2. What is the evidence of changes in the knowledge and behaviour of reached high risk populations?			✓		
3. What is the evidence that PLWH have increased capacity to lead healthier and safer lives?		✓			
4. What is the evidence that people who use drugs have increased capacity to lead healthier and safer lives?					✓
5. What is the evidence that the community has increased knowledge of HIV and related issues, as well as increased support for PLWH, people who use drugs and high risk populations?	✓				
6. What is the evidence that the organizational capacities of ASOs have been enhanced through ACHF funding?				✓	
7. What is the evidence that collaborative partnerships resulted in an expanded reach of HIV related services and support?	✓		✓	✓	✓
8. How have target population members been involved in program development, delivery and evaluation, and in the governance of ASOs?	✓	✓	✓	✓	✓
9. What is the evidence of changes to HIV-related policy and practice within other organizations and sectors?	✓				
10. What lessons have we learned about the effectiveness of the services provided?	✓	✓	✓	✓	✓
11. What emerged as good practice for each of the five ACHF funding approaches?	✓	✓	✓	✓	✓

Data Collection and Analysis

Each of the 14 funded organizations reported on their funding every six months, on a fiscal year basis. There were two reports from each group for 2008/09 which were mined for data and outcomes and then tallied together into results. Data was tallied either manually into tables (in cases where qualitative descriptions were important in analysis) or in Excel software, depending on the level of cross-tabulation. The total number of operational reports included in the analysis is 28. Throughout the report, there are direct quotations taken from the operational narrative reports which provide context and voice from agencies.

The ACHF reports completed by funded agencies for 2008/09 used a new style of narrative report that inquired directly about the output data elements in the framework, in addition to seeking outcome information through responses to common survey questions. As such, the data provided in 2008/09 is much more complete than in previous years.

Limitations

There are a number of limitations to the data presented in this report. The evaluator was required to select or code information in some instances, which may result in errors. For example, in some cases

agencies reported multiple target populations for a workshop, support activity or resource, resulting in the evaluator having to determine the most appropriate target population to which to code the data. Sometimes this interpretation was aided by the description of the activity, workshop or resource; in the absence of other clues, the first population listed was the one selected for coding.

In mining the narrative reports, there is the possibility of error by the evaluator in recording data properly by agency and in adding all the data together into summary form.

There are issues related to the contribution to the work by other funders. In some cases, work is not reported because a particular program is not funded by ACHF. For example, some agencies have volunteer programs or event planning funded by others so do not report results to ACHF. The more common scenario, however, is that ACHF work is supplemented by other funders, so reported results are greater than those achieved by ACHF funding alone. For each funding approach or section of the narrative report, agencies were asked to indicate the percentage of this work that is funded by ACHF. In most areas, these percentages ranged from 1-9% funded by ACHF to 100% funded by ACHF. All reported data was included in this analysis, but it must be noted that overall, the evaluation demonstrates work and results that clearly reflect productivity that is beyond what is funded by ACHF.

Another limitation relates to the fact of the new narrative report. As previously mentioned, the new style of report specifically asks for data related to the framework, which means that agencies are prompted to provide the data (they were not prompted under the old style of narrative). Therefore, we can expect to see better reporting of output data such as referrals or staff training events. It is difficult to interpret, however, if increases in outputs are reflective of increased activity or simply better reporting. Comparisons are made to 2007/08 data where possible, but are not interpreted. This 2008/09 evaluation year should be considered the baseline from which comparisons should be possible in future evaluations once complete data is being provided consistently. Furthermore, it can also be said that, in spite of the new narrative form, the 2008/09 year continues to have incomplete data as many groups worked to create local systems to collect all the data that is now requested in the narrative.

There are some limitations with respect to inconsistent data. Inconsistent data refers to the method of counting or tracking something, and reporting it that way consistently in each report. There can be consistency problems between an agency's two reports, and also between the reports provided by different agencies.

Incomplete data is another limitation with the report. The data throughout the report may be provided with some of these limitations noted. In most cases, it is noted how many agencies provided data for that output or outcome. Incomplete data refers to when an agency provided a data number in only one of their reports, such as providing condom distribution numbers in only 1 of 2 reports. Data may be incomplete for three reasons. First, agencies engage in work that meets their community's needs, so may not provide services for all fund approaches, or related to all outputs or outcomes. For example, some agencies focus more on the Prevention and Creating Supportive Environments fund approaches and have little or no data to report under Health Promotion. Incomplete data may also reflect the fact that an organization had other sources of funds supporting that area of programming. For example, if another funder supported a volunteer program, no volunteer numbers would be provided to ACHF from that agency. In addition, incomplete data may be the result of poor data collection and reporting by agencies.

Finally, ACCH holds contracts with both Alberta Health & Wellness and the Public Health Agency of Canada to administer the Alberta Community HIV Fund. As such, it does not report to ACHF using the ACHF Narrative Reporting Form. The data for ACCH was taken from ACCH's narrative reporting forms (Bi-Annual Project Evaluation and Reporting Tool) that they provided to the Public Health Agency of Canada.

Overview of ACHF Operational Funding

Table 2. Funding Allocations 2008-2009

	April 2008 - March 2009	
Organization	Operational	Harm Reduction
ACCH	352,832	
ABV	80,104	
AIDS Calgary	654,878	
CAANS	236,181	55,675
HIV Edmonton	857,445	
HIV North	149,476	41,758
HSSA	73,532	35,199
HWY	96,473	
Kairos House	87,077.50	
LHC	134,811	35,199
Safeworks		312,746
SHARP Foundation	87,077.50	
Streetworks		435,959
WBHAS	136,329	
TOTALS	2,946,216	916,536
Annual Funding	3,862,752	

Operational agencies provide varied services based on needs in their region, the nature of ACHF funding they received (e.g. harm reduction, regional programming, assisted living and/or provincial) and other factors. For a description of the services provided by each operational agency, please see the ACCH website at www.acch.ca

Output Data

Target Population Contacts

Agencies were asked to indicate the number of contacts they had with each of the target populations. Table 3 indicates that there were a total of 140,694 contacts with the various target populations in 2008/09.

Table 3. Contacts with Target Populations

Target Population	Number of Contacts
Practitioners/Professionals/ Service providers	22,987
Policy makers	2,698
General public	33,932
PLWH	9,912
Those affected	512
Gay men/MSM/GLBTQ	4,575
PWUID	25,718
Aboriginal people	2,924
Prisoners	697
Youth at risk	23,497
Women at risk	3,694
People from countries where HIV is endemic	702
At risk	3,184
TOTALS	140,694

Education and Awareness Activities

All 14 ACHF funded agencies were involved in education and awareness activities. The agencies were very active providing workshops, events and displays for practitioners, professionals and service providers on various topics, offering 341 sessions reaching over 12,742 individuals in 2008/09. Agencies provided education and awareness sessions to populations at high risk for HIV (youth/students, women, gay men/ MSM/GLBTQ, people from countries where HIV is endemic, prisoners, aboriginal people and at-risk), providing 355 sessions to 19,706 individuals. The general public was also targeted for HIV awareness and prevention, receiving 68 presentations, events and displays, reaching at least 15,998 people. Finally, there were 9 workshops and displays for people living with HIV, reaching 118 people.

Table 4. Education and Awareness Activities

Target Population	Workshops		Community Events		Displays	
	# Done	# Contacts	# Done	# Contacts	# Done	# Contacts
Youth	224	6,470	32	6,157	8	2,425
Women	2	40	2	80		
At risk	13	52	12	1,768	3	1,200
Aboriginal people	20	354	6	497	1	50
MSM/gay men/ GLBTQ			1	40	1	150
Prisoners	23	49			1	150
People from endemic countries	4	90	1	100	1	34
PLWH	6	66			3	52
Practitioners/ Professionals/ Service providers	323	6,899	12	248	6	5,595
General public	6	164	45	11,075	17	4,759
TOTALS	621	14,184	111	19,965	41	14,415

In addition, there were two conferences hosted: one for the general public with 67 contacts and one for practitioners/professionals/service (P/P/SP) providers with 350 contacts. There were also 86 agency tours provided to 703 practitioners/professionals/service providers.

Sample topics for the workshops included: HIV 101, universal precautions, HIV & the Public Health Act, mental health & addictions, sexual diversity, and predatory drug training. Sample community events included International Day Against Homophobia, Canada Day parade, International Youth Day, AIDS Walk for Life, Youth Gear Up and Project Homeless Connect.

“[We are] now part of monthly orientation for new Alberta Health Service Mental Health Staff. Presentations are done in collaboration with the Dual Diagnosis Clinic. Presentation includes Addictions, Mental Health, Harm Reduction. Two community members with a history of drug use share their experiences at each presentation.”

“One has to go in with the purpose of educating and not pushing to change individuals’ ways of thinking. No attempt is unsuccessful; it just means that more education needs to be done over time. Individuals are not likely to change their way of thinking overnight.”

“The Groove for Life event was a really fun event and drew 200 youth. Youth collected pledges or paid a \$10 fee to attend the Much Music Video Dance turned fundraiser. Booths and displays were onsite from six different agencies in the communities that cater to youth.”

Resources

All of the ASOs reported using and distributing various resources in their narrative reports. The narrative report asked for a complete listing of resources on both six month reports; however, due to the volume of data provided, only the October-March reports were used for this set of variables. The impact of this is that the data regarding the number of resources used may be under-represented, and the number of materials distributed is under-represented presuming that the same materials were listed on the first report. Nevertheless, there were 591 resources listed by the agencies as having been made available to the target populations, with at least 134,011 copies of these materials distributed. In many cases, agencies did not provide reproduction or distribution numbers for each resource. Also, some materials are distributed electronically (e.g. newsletters) so distribution numbers can be higher than reproduction counts. In addition, there were 14 websites mentioned by twelve agencies, which were updated 146 times in 2008/09.

Table 5. Type and Distribution of Resources by Population

Type of Resource	High Risk Populations			PLWH/ Those Affected			Community members/ P/P/SP			PWUD		
	# of docs	# reprod.	# distrib.	# of docs	# reprod.	# distrib.	# of docs	# reprod.	# distrib.	# of docs	# reprod.	# distrib.
Manuals/ Training kits				1	8	8	6	5	2,256	3	125	74
Brochures/ Pamphlets/ Posters	163	745	933	57	1,475	1,122	212	79,673	1,926	44	1,370	51,410
Communiqués/ Newsletters/ Articles	1			2	70	72	26	17,350	50,227	3	60	550
Presentations	12	3	9				37	238	329			
Position/ Research papers							8	376	418			
Other	8	25,000	23,250	1	25	25	7	3,200	1,402			
TOTALS	184	25,748	24,192	61	1,578	1,227	296	100,887	56,558	50	1,555	52,034

The following are some sample topics of the various types of resources:

Manuals/Training kits: Naloxone training kit, abscess kit, speaker’s network training manual
Brochures/Pamphlets/Posters: Women and AIDS, AIDS Walk for life posters, safer sex menu
Communiqués, Newsletters: Street Hype, Ellipse, The Skinny, The Quickie
Presentations: HIV/AIDS, harm reduction, universal precautions, sexual diversity

Position/Research papers: Federal election briefing document, Making a Difference Briefing document

Other: condom labels, poster presentation, booklets.

Outreach and Support

All 13 front line agencies delivered both outreach services and support services to a greater or lesser extent. Outreach includes: bar blitzes; street/walking outreach (early morning, day and evening); regular or occasional outreach at other agencies or locations such as shelters, addiction treatment facilities, bathhouses or jails; events such as raves, sex toy parties and sports tournaments.

“We have recognized that by going to the clients and treating them for minor cuts and bruises this has opened the door for conversations around risk behaviour and HIV/Hep C status. This has led to testing and also referral for treatment.”

“We have been able to do much more targeted prevention among youth and IDU through formal implementation of our ambassador populations. Our IDU ambassador has introduced us to many more people.”

Support includes programs such as peer support group meetings, 1-1 counseling, home visits, hospital visits, transportation, nutrition programs, client socials, on-site testing nights, complementary therapies, hotlines, advocacy/human rights support, resident outings, pre- or post-test counseling. It also includes support such as drop-in and use of the telephone or internet (access to facility).

“Many of my clients with long-term HIV infection are having increasing health concerns and are becoming somewhat more limited in their mobility. This had led to increased home visits but it’s not an option for everyone.”

“I’ve become increasingly aware of many of my clients having some memory loss, and in response to this I have been checking in more regularly with my clients instead of waiting for them to contact me.”

The following table does not include any outreach occasions or contact numbers identified as directly related to needle exchange. Other services provided to individuals by harm reduction programs are included below (e.g. sessions with prisoners, outreach at a youth centre), but occasions and contacts related directly to needle exchange are addressed on page 15.

The agencies provided outreach on at least 3,789 occasions, resulting in 53,266 contacts. Support was provided on 6,576 occasions, with 19,127 contacts. However, it should be noted that there appear to have been some issues with the instructions provided to agencies on how to complete a particular table in the narrative report, so it’s likely that the outreach and support work is under reported.

Table 6. Outreach and Support to Target Populations

Target Population	Outreach		Support	
	# Occasions	# Contacts	# Occasions	# Contacts
Youth	149	14,316	62	149
At risk	486	8,648	4,384	11,257
Women	7	4,946	39	258
Aboriginal people	105	365	10	40
Prisoners	105	878		
MSM/GLBTQ	174	3,558	24	167
People from countries where HIV is endemic	9	59		
People who use drugs	2,600	20,070	158	3,330
PLWH	58	330	1,877	3,904
Those affected	96	96	22	22
TOTALS	3,789	53,266	6,576	19,127

NOTE: In some circumstances, ASOs spoke of an outreach or support program but provided data for only either occasions of service delivery or contacts. For example, one agency did not indicate the number of outreach occasions for women but indicated having 2,556 contacts with women through outreach. Another agency did not enter any support or outreach information for one six-month period.

Condoms

Condom distribution numbers were provided by 11 agencies, for a total of 211,238 condoms distributed in 2008/09. This data is fairly complete, with data missing from only 2 of 22 reports from those 11 agencies. This number is roughly half of the condoms reported as distributed in 2007/08.

Tests

Two agencies reported on the number of tests that they performed, for a total of 2,278 tests in 2008/09. These included tests for HIV, Hepatitis A/B/C, Syphilis, Chlamydia, and Gonorrhea. This number is comparable to the 2,392 tests reported in 2007/08.

Pre- and Post-Test Counseling

Three agencies reported doing pre- & post-test counseling with clients. There were 2,292 occasions of pre-test counseling and 2,058 occasions of post-test counseling provided.

Prevention Referrals

Nine agencies reported referrals under their prevention programs, meaning referrals for high risk populations. Health referrals were to places such as testing sites, doctors, addictions treatment, dentists, and mental health care practitioners. Examples of community referrals were to clothing banks, shelters, food banks, social service agencies, housing supports and income support. There were 3,982 referrals reported for high risk populations. This is an increase over the 980 referrals reported in 2007/08.

Table 7. Prevention Referrals

Type of Referral	Number of Referrals
Health	2,056
Community	1,926
TOTAL	3,982

Health Promotion Services

The Evaluation Framework seeks information on the types of services provided to people living with HIV and those affected, as well as the number of contacts for each type of service. This data is only available for PLWH, not for those affected. Services for PLWH provided by the assisted living facilities are not included, and it was oftentimes difficult to ascertain contacts with PLWH for programs such as “access to facility” because agencies included many different target populations in some service descriptions and contact counts.

Table 8. Services and Contacts for PLWH

Type of Service	Number of Contacts
Social and nutritional programming	956
Peer support	123
Recreation	5
Access to facility	3,451
Counselling and emotional support	1,308
Transportation and basic supports	359

Health Promotion Clients

The target populations for health promotion programs are people living with HIV/AIDS and those affected. Ten agencies reported client numbers for their health promotion program. It is likely that not all of the clients reported in the health promotion program are HIV positive. In some cases, it may be difficult for agencies to determine the HIV status of individuals seeking service. Agencies reported health promotion client caseloads of 1,063 individuals in the first reporting period and 1,062 individuals in the second reporting period. This is an increase over the 364/274 clients reported in 2007/08.

Demographics

The Evaluation Framework seeks demographic data only for health promotion clients; this group tends to have long term relationships with the agencies that are more likely to be documented using case files or notes from which demographics can be examined. Nine agencies provided basic demographic data regarding health promotion program clients in at least one of their narrative reports.

Summary gender information is as follows:

- Report 1: 969 individuals, 34% female, 65% male and 1% transgendered.
- Report 2: 991 individuals, 32% female, 67% male and 1% transgendered.

The presentation and interpretation of the cultural background data is not possible due to the manner in which the data was requested in the narrative report. It's difficult to present the variation in the two reports, and there were clear inconsistencies among the agencies in how they were interpreting the many categories offered for cultural background (e.g. one agency reported 62% "other Canadian" and one agency reported 77% "Eastern European" while another reported 66% "Western European").

Health Promotion Referrals

Eleven agencies reported referrals under their health promotion programs. Health referrals were to STI clinics, HIV clinics, doctors, addictions treatment, dentists, and mental health care practitioners. Community referrals were to clothing banks, shelters, food banks, social service agencies, housing supports and income support. Agencies provided 7,616 referrals of health promotion clients to health and community services. This is an increase over the 1,154 referrals reported in 2007/08.

Table 9. Health Promotion Referrals

Type of Referral	Number of Referrals
Health	3,107
Community	4,509
TOTAL	7,616

Assisted Living

The revised Evaluation Framework includes a new series of data for the two assisted living programs to report upon. These outputs reflect the total number of clients in the assisted living facilities who were served in intensive, long term and/or transitional care.

Table 10. Assisted Living

Output	Number of Clients April – September, 2008	Number of Clients Oct., 2008 – March, 2009
# PLWH served in 24/7 intensive care	4	4
# days of 24/7 intensive care	61	50
# PLWH served in long term care	20	20
# PLWH (residents) served in transitional care	5	3
# PLWH (non-residents) served in transitional care	5	4
# residents who passed away	4	1

Clients Who Passed Away

Six agencies indicated that 24 people had passed away in the community during 2008/09, which is an increase over the reported 10 individuals who passed away in 2007/08.

Needle Exchange Services

The six needle exchange programs provide services to clients through the locations described below, as well as through various other forms of outreach such as attending raves, visiting other agencies and attending community events such as annual boot giveaways or other service fairs. These types of outreach activities were reported in Table 6: Outreach and Support to Target Populations.

The harm reduction programs reported an estimated number of clients served through their harm reduction programs: 4,050 individuals in the first six months and 5,349 individuals in the second six months. They reported a total of 50,585 contacts with people who use drugs through their harm reduction programs.

Needle Exchange Locations

The needle exchange programs offer needle exchange at more than one location. The data provided indicates that there are 37 fixed locations, two mobile vans and four agencies that do street or walking outreach. This is an increase from 22 fixed locations in 2007/08.

Table 11. Needle Exchange Locations

Type of Location	Number of Each Location
Agency office	5
Pharmacy	12
Other agencies	20
Mobile van	2
On foot/street outreach	4
TOTAL	43

Needle Distribution

Six agencies operated needle exchange programs funded by ACHF. There were 1,112,883 needles reported distributed in 2008/09, compared to 1,124,413 needles reported distributed in 2007/08.

Table 12. Needle Distribution

Organization	April 2008 - September 2008	Oct 2008- March 2009	Total	% of Overall Total
CAANS	49,181	40,947	90,128	8.10
HSSA	27,800	38,041	65,841	5.92
HIV North	7,659	6,030	13,689	1.23
LHC	6,535	5,380	11,915	1.07
Safeworks	184,667	171,547	356,214	32.01
Streetworks	259,827	315,269	575,096	51.68
TOTALS	535,669	577,214	1,112,883	100.00

Type of Supplies

The six needle exchange programs reported on the type of harm reduction supplies that they distribute besides needles. "Other" supplies included crack pipes, glass tips, push sticks, brillo and matches (safer crack use supplies distributed individually rather than assembled as a kit), condoms and lube.

Table 13. Harm Reduction Program Supplies Distributed

Type of Supplies	# Agencies Distributing
Safer inhalation kits	2
Mouthpieces for crack pipes	3
Filters	4
Alcohol swabs or wipes	6
Sharps containers	6
Ties or tourniquets	5
Water	5
Cookers	2
Bleach	1
Piercing kits	1
Citric	1
Other	3

"There has been an increase of between 100-150 contacts per month since the distribution of crack pipes was commenced."

Ride-alongs

Ride-alongs are reported by the two harm reduction agencies that operate a mobile van as a component of their program. Together, they reported a total of 245 ride-alongs, with 64 agencies represented on the ride-alongs.

"The ride-along participants reported increased knowledge, understanding and comfort in all of the concepts except for a slight decrease in comfort level working with people who have addictions. This may be explained by a false sense of comfort reported by the participants before going on the ride-along, and perhaps the experience of a "reality-check" about the challenges of working with street-involved people who have addictions after the ride-along."

Media

Thirteen of the fourteen agencies reported having engaged with media during 2008/09. Agencies reported receiving media coverage 473 times, with newspaper articles being the most frequent coverage with 189 articles. Coverage in the "other" category included editorials, on-line newsletters and articles in other organizations' newsletters. This is an increase in media coverage from 280 occasions in 2007/08.

Table 14. Media Coverage

Type of Media Coverage	Frequency of Coverage
Newspaper articles	189
Radio	89
Television	82
Public service announcements	63
News releases	50
TOTAL	473

Sample topics of media coverage include:

Client personal stories	Federal election
World AIDS Day	Federal funding cuts
AIDS Walk	Street nursing
HIV and sexual health	HIV testing
Cancelled annual fundraising event	Special events (e.g. United Way campaign)

“Conservative media can be challenging, having good rapport with a few reporters is helpful, being able to identify a hidden agenda is crucial in getting the message across.”

Community Action Issues

Agencies are all active in addressing issues in their community related to creating supportive environments for people living with HIV. This list of issues was compiled using various data elements in the narrative reports: lists and names of committees, approaches to improve others’ capacity, policy areas intended to influence, lessons learned, descriptions of partnerships and partnership-related outcomes, special stories and attached documents. The following is the range of community action issues that ASOs are involved with: housing/shelter, NPNU, addictions, MSM/GLBTQ, sexual health, sex trade, newcomers/people from countries where HIV is endemic, health/nursing, funding, harm reduction, drugs/drug strategies, non-profit sector, testing, needle debris, and youth.

Methods Used to Improve Other Organizations’ & Professions’ Capacities to Address HIV

The ACHF narrative includes a series of questions regarding specific approaches taken by agencies to improve other organizations’ and professions’ capacities to address HIV. Table 15 summarizes the agencies’ responses to this inquiry.

Table 15. Approaches Taken to Improve Other Organizations’ and Professions’ Capacities to Address HIV

Approach	Number of Agencies	Number of Described Activities
Provided training	14	323
Developed resources/tools	9	21
Developed a new group	10	19
Other action	10	24

The training referred to above is the workshops/presentations that were provided to practitioners/professionals/service providers that is described on page 9. Examples of the other approaches include:

Resources/tools: Pandemic Planning for Agencies; Briefing document: HIV/AIDS – Occupational Exposure and Health Professionals; presentation on safer pregnancy

New groups: local harm reduction network, Outreach Nurses Networking Group, Brooks Action Committee on HIV, local support group for drug users

Other: work with city to develop new handout for water bills about what to do if you find a needle; needs assessment of training needs for RHA 5 & 7; Calgary Police Service Sexuality and Gender Diversity Liaison Committee; working with housing committee to support Aboriginal women living with HIV and addictions.

“We developed a new group in Alberta for nurses who work directly with street populations. The purpose of the group includes: resource sharing, sharing style, models of service delivery, education, policy review, advocacy and mentorship.”

Agencies were also asked what actions they took to influence policy during 2008/09.

Table 16. Actions to Influence Policy

Actions	Number of Agencies	Number of Described Activities
Developed working relationship with government or community representative who can provide access to policy process	9	16
Held meetings with policy makers	6	16
Participated in policy development process with policy makers	5	10
Presented briefs or position papers	3	3
Prepared and distributed a policy research report	1	2
Other actions	4	9

Examples of actions to influence policy included:

Working relationships: Medical Officers of Health, city planning departments, MLAs, MPs, College of Dental Assistants

Held meetings: school principals, health regions, community planning departments, city councillors, harm reduction networks, Alberta Advisory Committee on HIV & STIs

Policy development process: develop communication plan for needle exchange program, develop policies on behalf of Quality End of Life Coalition of Alberta, consultation on human rights law and practice

Briefs: Making a Difference (funding brief), Continuum of Housing and Supports for PLWH

Policy research reports: HIV and Housing Report, Making Communities Stronger: Developing HIV/AIDS Services for African Newcomer Communities in Calgary

Other: media releases, procedures report regarding sharps disposal and needle exchange at partner agency, policy and procedure manual for street outreach partner, use of media.

ACHF funded organizations also used other methods to improve other organizations’ and professions’ capacities to address HIV, as illustrated by table 17.

Table 17. Methods Used to Improve Other Organizations' & Professions' Capacities to Address HIV

Method Used	# Agencies Involved	# Times Method Used
Partnerships	13	216
Ride-alongs/tours	3	331
Practicum students	13	156

“Working directly with self-regulating professional associations who are responsible for enforcement of professional standards amongst their membership is an effective way to reach health providers with education regarding the laws and policies (i.e. codes of conduct) that govern their professions. Rather than asking for new HIV specific policies to be created, it may be more effective to focus on starting new educational initiatives that raise awareness of existing laws and policies. Some sort of evaluation component should be built into such educational initiatives to gauge the actual impact of the education strategy on the everyday practice of health practitioners.”

New Policies or Practices within Other Organizations or Sectors that Impact HIV Programming

ASOs provided a number of examples of new policies or practices within other organizations or sectors that impact HIV programming:

- Local detox centre is now requesting crack supplies.
- Local company decided to cover the cost of having all their employees vaccinated for Hepatitis A and B if they chose to do so.
- An organization realized the importance of having gloves available and now provide boxes for in office use and in their individual work vehicles.
- Conversations with local ambulance authority regarding their apparent need to have all information about [client] health status revealed. We will not release medical information that is not related to the health crisis we have called about and they have taken this matter to the supervisory personnel.
- Local community drug council is reviewing policy relevant to HIV+ clients and has an HIV+ member sitting on a subcommittee.
- We now have medications being delivered to our location for clients who do not have refrigeration.
- Clients are now being scheduled for testing or treatment through our office with input from staff as to the best method for the individual client.
- Began a new partnership to train local Emergency Medical Service new recruits as part of their diversity training.
- Worked with College of Alberta Dental Assistants to create an online continuing competency course for dental assistants. The course materials include [ASO's] three articles and a new quiz/answer key developed to test knowledge after reading the articles. A total of 42 dental assistants took and passed the course.
- Local shelter/partner agency has developed written procedures regarding sharps disposal and needle exchange.

- ASO convinced a municipal government of the need for a sexual health line to provide anonymous access to sexual health information to reduce rates of HIV, syphilis and other STIs. City tasked local ASO with development, implementation and evaluation of the sexual health line.
- Oil company health and safety committee developed a needle disposal program.

ACHF Funded Staff

While a variety of information about staff was requested on the narrative, the information presented here is incomplete. In some cases the data was not provided, in other cases it was provided in an alternate form such as a % of staff funded by ACHF rather than the number. The total number of staff was reported as 103 (missing data from 2 agencies) in the first reports and 129 in the second reports. Of the 129 staff reported on the second report, at least 47.85 full time equivalents were funded by ACHF (missing data from 2 reports). In addition, 43 of the 129 total staff reported on the second reports had been retained for more than 2 years.

Students

Information about the number and type of students doing placements or work experience at agencies was reported by thirteen agencies, for a total of 156 students, an increase from 104 students reported in 2007/08. The study areas of students included: nursing, medical school, social work, pharmacy, aboriginal community worker, public relations, health care aids/personal care attendants, massage therapy, marketing, international/community development, physical education, science and non-profit management.

Volunteers

Volunteers are a vital part of any community-based agency, providing needed support from the community for the management and operation of programs. Eleven agencies reported their number of volunteers. There were a total of 524 volunteers reported from April to September, and 534 volunteers from October to March. These are comparable to the number of volunteers reported in 2007/08 (602/545). Volunteers provided 12,972 hours over the course of the year.

“We have recruited a lot of our new volunteers from the YMCA. Many of the new volunteers are men from endemic countries. These men are assisting in program planning, support groups, and program delivery.”

Volunteers were involved in a variety of activities, as illustrated by Table 18. “Other” included physical labour, yard maintenance, office move, archivist, doing presentations and working on computers.

Table 18. Volunteer Activities

Type of Volunteer Activity	Number of Agencies Reporting
Administration	7
Advisory committee/board of directors	10
Support/assistance for PLWH	6
Prevention/education	10
Fundraising	8
Special events	11
Peer support	10
Other	6

Boards of Directors

Agencies were asked to report on the number of board of director’s positions and the number of positions that were full in each six month period. With 9 agencies reporting data, 90% of board positions were full throughout the year. There were 88 board meetings reported by the 9 agencies throughout the year.

Staff and Volunteer Training

Staff training was offered by all 14 agencies; volunteer training was reported by 12 agencies. The total of 383 staff trainings is an increase over the 145 staff trainings reported in 2007/08; the 72 volunteer trainings is an increase over the 12 trainings reported in the previous year.

Table 19. Staff and Volunteer Training

Nature of Training	Staff		Volunteers	
	# Trainings	# Attendees	# Trainings	# Attendees
Agency management	124	273	33	117
Client-related issues	75	182	4	21
Population-specific	26	47		
HIV/HCV/STI, harm reduction	98	246	28	95
Other organizations	60	144	7	13
TOTALS	383	892	72	246

“Conference attendance has increased the agency’s capacity to integrate knowledge and practices of current trends faced by PLWHAs in Canada and abroad, as well as giving the agency the opportunity to share its own research.”

Examples of the various training types include:

Agency management: agency volunteer training, community development, volunteer management, taxable benefits, HOMES training

Client-related issues: family violence, first aid, mental health, abuse prevention and response, medication administration, fetal alcohol spectrum disorder

Population-specific: enhanced services for women, Aboriginal awareness training, “trans talk,” drug use in pregnancy

HIV/HCV/STI, harm reduction: HIV disclosure, dynamics of HIV, HIV 101, treatment
Other organizations: ACCH meetings, Alberta Harm Reduction Conference, Canadian AIDS Society, Canadian AIDS Treatment Information Exchange (CATIE).

“Community members help in a multitude of ways to the best of their ability. Their skill sets are somewhat varied and sometimes limited. Each time someone helps in a small way, they do not get an orientation. We more likely seize the moment with an eye to expanding their roles.”

Planning and Evaluation Documents

Data regarding planning and evaluation documents was provided by eleven agencies. Ten agencies indicated that they had strategic plans and 4 agencies indicated that they had succession plans. Other planning documents mentioned by two agencies included an agency work plan and an agency evaluation.

Funding

While the series of questions about other sources of funding was asked on both reports, data from only second set of reports will be used for ease of analysis. When asked how many other sources of funding they had, agencies reported a total of 119 other sources of funding, with a range between agencies of 1-73 sources (73 includes individual donors). In total, there was \$2,699,655 in funding reported by the agencies, from the following types of funding sources:

Table 20. Types of Other Funding Sources

Type of Other Funding Source	Number of Agencies Reporting
Other Public Health Agency of Canada	8
Other federal	2
Alberta Health & Wellness	1
Other provincial	5
Municipal/regional	4
Health Authority	3
Non-profit/charitable/foundation	5
Fundraising	9
Other	3

Routine Data Collection and Analysis

The move to the new style of narrative reporting has greatly increased the reporting of output and outcome data to ACHF. However, in order to report data, agencies must have local data collection systems in place and functioning. Oftentimes, data that was missing on the first set of reports was provided on the second set, indicating increased local data collection systems to collect and report required data. Thirteen agencies provided evidence of routine data collection and analysis to modify programming. There is evidence that agencies are collecting a broader range of data, using that data to

revise their programs, doing needs assessments, engaging in community-based research projects and conducting more surveys to measure outcomes. Thirteen agencies provided survey results to measure outcomes with various populations, an increase over seven agencies in 2007/08.

Methods of Receiving Client Feedback

Receiving feedback from clients is critical to continual adjustment and improvement of programming. Every agency reported receiving feedback using at least one of the methods described in the following table. The most common methods used were informal conversation (all agencies) and client surveys (13 agencies). The “other” methods included anonymous feedback boxes and question of the month.

Table 21. Methods of Receiving Client Feedback

Method	Number of Agencies Using
Informal conversation/routine interaction	14
Client surveys	13
Presentation evaluations	12
Focus groups	8
Client interviews	8
Meeting evaluation forms	7
Resident meetings	2
Other	3
TOTAL	67

“Through informal conversations with women at the Sex Trade Drop In as well as with conversations with clients including PLWHA, we determined that there was a need for medical assistance to aid with questions, advice and minor wound and foot care. This led to [our] advocating on behalf of clients for further funding to provide street outreach nursing.”

Range of Evidence that Informs Programming

All ACHF funded organizations used at least one type of inquiry or evidence to inform their programming. The most common forms of evidence were surveys (12 agencies), evaluations (12 agencies) and focus groups (8 agencies). “Other” types of inquiry reported included partnerships and monitoring epidemiology reports.

Table 22. Range of Evidence that Informs Programming

Type of Inquiry	Number of Agencies Using
Survey	12
Evaluation	12
Focus groups	8
Community based research	7
Interviews	7
Needs assessments	6
Strategic planning	6
Environmental scans	5
Other	2
TOTAL	65

Partnerships

All ACHF funded agencies are involved in partnerships which are described in varying degrees of detail in the narrative reports. The partnerships included below are only those that were described in sufficient detail to be determined as collaborative and substantial partnerships. The table below includes data from 13 agencies; while one agency indicated that they had partnerships, they did not provide any detail on the names or descriptions in order to be included here. As described in the table below, the agencies hold a range of partnerships from a variety of sectors to address the determinants of health. There were 216 collaborative partnerships reported, with 50% of partnerships reported as being with not for profit organizations, primarily in the health and social services areas.

Table 23. Partnerships by Sector and Area of Focus

Area of Focus	Private Sector	Public Sector	Not for Profit Sector	Other	Total
Health	14	32	65	2	112
Education	3	9	4	2	18
Social services		5	22	1	28
Aboriginal			5		5
Housing		4	7		11
Justice		10	2	1	13
Academia/research		1		1	2
Recreation	11				11
Industry	7				7
Transportation	1				1
Other		2	3	3	8
Total	36	62	108	10	216

Another partnership-related output in the evaluation framework is the number of partnerships with other ACHF funded agencies. Nine agencies identified specific partnerships with other ACHF funded agencies, for a total of 35 partnerships. These are reflected in the not-for-profit health sector cell above.

“Our many various partnerships including those with Aboriginal groups and GALA [Gay and Lesbian Alliance] help us become connected to groups at higher risk for HIV.”

Finally, all six needle exchange programs funded by ACHF reported having partnerships with their Regional Health Authority or Alberta Health Services.

The nature of these partnerships involved:

- providing staff on a regular basis to support each other’s work (e.g. doing street outreach together, regular shifts on needle exchange van)
- co-hosting outreach, fundraising and educational events (e.g. Vagina Monologues, National Day Against Homophobia)
- referring and mutually supporting clients (extending reach to other populations)
- promoting one another’s services
- conducting research projects or needs assessments for specific populations
- keeping one another updated on emerging issues, trends and information

- co-developing resources
- providing training to each other's staff
- co-sponsoring programs.

Nature of Target Population Involvement

The ACHF narrative reports asked operationally funded agencies to describe how members of their target population are involved in the day to day work of the organization. It is noted that there can be two interpretations for the first line in the table: either that the column is not applicable because the agency does not serve that target population or that they do serve that target population but the target population was not involved.

Table 24. Nature of Target Population Involvement

Nature of Involvement	Number of Agencies Reporting Involvement		
	High Risk Populations	PLWH	P/P/SP
Not applicable. Target population did not contribute to management and/or delivery	1	4	
Target population were given informal opportunities to express their view or opinions about the program	10	9	13
Target population were given formal opportunities to express their view or opinions about the program (needs assessment, evaluation, interview, focus group)	11	10	9
Target population played a volunteer role in delivery of programs	12	7	11
Target populations were directly involved in a committee or group that provides advice to the governing body	9	7	11
Percentage of agency decision makers that were members of the target population(s) (e.g. by sitting on advisory or governing body)	Less than 25%	7	8
	Between 25% - 50%	5	2
	More than 50%		9
Target populations were employed by the program	7	2	6
Other	1	1	

NOTE: HIV status is not necessarily known for all members of the involved target populations.

The following are some specific examples of how target populations have been involved in ACHF funded organizations:

- acting as peer ambassadors
- working for the agency in contract and casual positions
- electing a resident representative to the board each year
- attending monthly resident meetings
- speaking at workshops, conferences and presentations
- planning special events and fundraisers
- assisting with condom blitzes
- providing peer hospital visits

- writing articles and suggesting content for newsletters
- participating in focus groups
- volunteering in weekly drop-in program
- planning conferences such as Alberta Positive Voice Conference
- sitting on committees and working groups, in addition to boards of directors.

“In October, we hired our HIV+ client to write articles for our agency’s newsletter. Her writing skills and knowledge of HIV has lead to us creating an informative newsletter with accurate and up-to-date information.”

“Peer Hospital Visits – 4 client volunteers have been participating in peer hospital visits to people with a history of drug use who are experiencing extended stay in hospital. Referrals are made from other organizations who know of someone in hospital that fit the criteria and would like a peer visit. The volunteer is given bus tickets to get to and from the hospital. In the initial visit peers evaluate the needs of the hospitalized individual and then return for subsequent visits with anything the individual might need (e.g. socks, magazines). The visits help to encourage individuals to remain in hospital. The volunteer feels valued for offering this support and contributing to his community.”

Evaluation Question Analysis

Some evaluation questions are analyzed looking at the results related to only one outcome. Others, however, require examination of multiple outcomes. In these circumstances, an additional subheading is added to summarize all the outcome results linked to the evaluation question.

Evaluation Question 1: Are the short term outcomes in the Provincial Evaluation Framework being achieved?

The evidence for this evaluation question is linked to outcomes under each of the five fund approaches. Outcomes are presented in italics, followed by a summary of the evidence regarding each outcome.

Prevention

High risk populations are more knowledgeable about HIV/AIDS including transmission, prevention and risk behaviour.

Agencies provided education and awareness sessions to populations at high risk for HIV (prisoners, youth/students, aboriginal people, women, MSM/gay men/GLBTQ, people from countries where HIV is endemic, and at-risk individuals), totaling 355 sessions to 19,706 individuals. There were 184 materials available for high risk populations, with over 24,000 copies of these materials distributed.

Nine agencies provided a total of 2,144 surveys that asked high risk individuals to rate their knowledge of HIV and risk behaviour before and after the workshop. Overall, there was a change from 11% reporting excellent knowledge before to 36% reporting excellent knowledge after, and an increase from

18% reporting very good knowledge before to 45% reporting very good knowledge after the workshop. From the same sample, 92% of respondents said that as a result of this workshop, they have more knowledge about how to protect themselves from HIV.

Six agencies provided results from a more detailed knowledge survey with high risk populations (n=1,067). This survey asked specific questions to test knowledge of HIV transmission rather than simply asking about increased knowledge. In this sample, 86% were able to correctly identify that there is not a good chance of contracting HIV from “french” kissing someone who is HIV positive.

There is evidence that high risk populations are more knowledgeable about HIV/AIDS, including transmission, prevention and risk behaviour.

High risk populations have access to safer sex resources (condoms, etc.), prevention messaging and social support.

High risk populations, including youth, women, Aboriginal people, at risk individuals, prisoners and MSM/GLBTQ and people from countries where HIV is endemic, were provided prevention messaging through outreach on 1,035 occasions, providing 32,770 contacts with high risk individuals. High risk populations were provided support services on at least 4,519 occasions, providing 11,871 contacts with high risk populations. Agencies provided education and awareness sessions to populations at high risk for HIV (youth/students, prisoners, Aboriginal people and at-risk), providing 355 sessions to 19,706 individuals. There were 184 materials available for high risk populations, with over 24,000 copies of these materials distributed. ASOs distributed at least 211,238 condoms throughout 2008/09. There is evidence that high risk populations have access to safer sex resources, prevention messaging and social support.

ASOs have partnerships for HIV prevention initiatives directed at high risk populations.

Based on the description of partnerships on page 24, there is evidence that ASOs have partnerships for HIV prevention initiatives aimed at high risk populations. Most of the partnerships with health and social service agencies in the not-for-profit sector are partnerships that enhance outreach, by providing preventive outreach services to high risk populations at locations such as addictions treatment facilities, shelters, and youth agencies.

Health Promotion

PLWH and those affected by HIV/AIDS are more knowledgeable about HIV related issues.

There were six workshops provided to people living with HIV/AIDS (PLWH), resulting in 66 contacts, in addition to three displays reaching 52 people living with HIV. Most information that is provided to PLWH on HIV related issues is through the health promotion outreach and support programs. There were 58 outreach occasions providing 330 contacts with people living with HIV, and 1,877 occasions of support provided to PLWH, involving 3,904 contacts with individuals. There were 96 outreach occasions making 96 contacts with those affected by HIV/AIDS, as well as 22 support occasions involving 22 contacts with those affected by HIV/AIDS. There were 61 resource materials targeted to PLWH and those affected, with at least 1,227 copies distributed.

Six agencies provided a sample of 56 surveys conducted with people living with HIV. Of the sample, 91% either strongly agreed or agreed that they are more knowledgeable about HIV related issues because of the support of the ASO. Three agencies provided a sample of 16 surveys with those affected in which 92% said that they have more knowledge of HIV related issues because of the support of the ASO. There is evidence that people living with HIV and those affected are more knowledgeable about HIV related issues.

PLWH and those affected by HIV/AIDS have access to appropriate and non-judgmental supports in ASOs, including other PLWH.

Agencies reported serving 1,063 health promotion program clients during the first reporting period and 1,062 clients during the second reporting period. Based upon the number of contacts that agencies reported with Health Promotion program clients (9,912), it is clear that they have access to supports in ASOs. Seven agencies offered peer support programming or group support through social activities and events. Six agencies reported survey results (n=59) in which 97% of clients strongly agreed or agreed that ASO staff members treated them with dignity and respect and 96% of clients strongly agreed or agreed that the services provided to them are useful and appropriate to their needs. Three agencies reported results from surveys (n=12) conducted with those affected indicating that 100% of respondents strongly agreed that the agency provided them and their loved one with non-judgmental supports. There is evidence that PLWH and those affected by HIV/AIDS have access to appropriate and non-judgmental supports in ASOs, including other PLWH.

PLWH have access to 24/7 intensive care and end-of-life care.

Through the two assisted living organizations, there is evidence that PLWH have access to 24/7 intensive care and end-of-life care. Four people in each six month period were provided intensive care and five individuals who passed away received end of life care. It should be noted that ACHF funds 18 beds in the assisted living facilities, and some residents are in transitional care, meaning that they are being supported towards independent living rather than in intensive or end-of-life care. There will only ever be a small sample size for this outcome based on the number of beds ACHF funds.

Harm Reduction

Individuals have increased knowledge of and access to harm reduction services and information.

Needle exchange programs offer services directly related to needle exchange, as well as related services such as information and referral, health-related services, support services and outreach. There were 2,600 outreach occasions serving people who use drugs that were not directly related to needle exchange, with 20,070 contacts, and 158 support occasions with 3,330 contacts. The harm reduction programs reported 50,585 contacts with harm reduction program clients overall (including exchange-related contacts). The needle exchange programs distributed 1,112,883 needles in 2008/09, in addition to other supplies such as water, citric, crack kits, mouthpieces, piercing kits, cookers and pipes. In addition, 50 resource materials were available for people who use drugs, with 52,034 copies of materials distributed.

Five agencies reported outcome results from the Harm Reduction Client Survey (n=237). In the survey, 51% of respondents said services were always available and 47% of respondents said services were sometimes available when they needed them. In terms of getting the supplies they need to have safer

sex, 66% said they can always get the supplies and 32% said they can sometimes get the supplies. When asked about the supplies needed to use safely, 50% of respondents said that they can always get the supplies they need and 47% said they can sometimes get the supplies they need.

There is evidence that individuals have access to harm reduction supplies and information. While the survey questions did not ask directly about knowledge of harm reduction services and information, the fact that they are able to rate their ability to access services implies knowledge of services. There is evidence that this outcome has been achieved.

There is appropriate availability of harm reduction supplies.

Harm reduction supplies are accessible through six agencies which offer supplies through at least 43 different locations. The number of locations through which supplies are available increased from 26 locations 2007/08 to 43 locations in 2008/09. There is evidence of appropriate availability of harm reduction supplies.

Creating Supportive Environments

Community members and partners have up-to-date information on HIV/AIDS and related issues.

Community members and partners were provided up-to-date information through a variety of means. Agencies received media coverage on a reported 473 occasions, and provided 414 workshops, presentations, displays, conferences and other events to the general public and practitioners, professionals, and service providers. These events reached at least 29,157 individuals. In addition, 296 resources for community members and practitioners/professionals/service providers were available, with over 56,000 copies distributed. Twelve agencies hosted and updated websites that provide information to community members and partners (146 updates). There is evidence that community members and partners have up-to-date information on HIV/AIDS and related issues.

Community members and partners have awareness & knowledge of HIV/AIDS.

In addition to the workshops and materials described above, the 245 ride-alongs were another means of creating increased awareness and knowledge of HIV/AIDS and related issues. The number of students (156) and number of volunteers (542/534 per six month period) are additional measures of community member awareness of HIV/AIDS.

Eight agencies provided results from surveys (n=324) conducted with practitioners/professionals/service providers that asked participants to rate their knowledge of HIV/AIDS before and after a workshop. Overall, there was a change from 4% reporting excellent knowledge before to 20% reporting excellent knowledge after, and an increase from 18% reporting very good knowledge before to 56% reporting very good knowledge after the workshop. There is evidence that community members and partners have awareness and knowledge of HIV/AIDS.

Strengthening Community Based Organizations

ASOs demonstrate capacity for program planning, implementation, evaluation and reporting.

The results presented earlier regarding increased evidence of routine data collection and analysis among all agencies is evidence that this outcome is being met. There is evidence that agencies are collecting more data, conducting evaluations, using that data to revise their programs, engaging in community-based research projects and providing more outcome measurement. Thirteen agencies (up from seven) provided survey results to measure outcomes with various populations. The number of agencies (11) reporting a variety of planning and evaluation documents is further evidence of program planning and implementation capacity. Reporting of output and outcome data increased from 2007/08, as well as increased from the first report to the second reports in 2008/09. ASOs have demonstrated capacity for program planning, implementation, evaluation and reporting.

Staff retention is increased.

Forty-three of the 129 total staff reported on the second reports had been retained for more than 2 years. Because this is the first year of data for this output, this must be considered baseline data, so there is not yet evidence whether staff retention increased. There is no evidence for this outcome.

Staff and volunteers are provided the training necessary to offer quality services.

Staff and volunteers were offered 455 training opportunities with a total attendance of 1,138. Staff and volunteers received training on topics related to agency management, client-related issues, population-specific issues, HIV/HCV/STI, harm reduction, and other organizations. Agencies provided outcome survey results regarding the trainings provided. The percentages in the table below are those who strongly agreed or agreed with the statement in the survey question.

Table 25. Staff and Volunteer Training Results

Survey Questions	Staff (n=357)	Volunteers (n=57)
I will be able to use the information I received in my work.	98%	99%
I have learned new skills that will help me in my work.	91%	100%
The conference/workshop/training provided me with the opportunity to network with my peers.	93%	97%

There is evidence that staff and volunteers are provided the training necessary to offer quality services.

Analysis of Evaluation Question 1: Are the short term outcomes in the Provincial Evaluation Framework being achieved?

As detailed above, there is evidence that 12 of the 13 short term outcomes in the ACHF Evaluation Framework were achieved.

Evaluation Question 2: What is the evidence of changes in the knowledge and behaviour of reached high risk populations?

The evidence for this evaluation question is linked to the following intermediate term outcome in the prevention fund approach:

Reached populations make informed and healthy choices around sexual health and risk behaviours.

There are a number of outputs that can be examined here, in addition to some survey results. One healthy choice demonstrated by reached populations is the number of tests; two agencies reported conducting 2,278 tests in 2008/09. Seeking referrals is another indicator of healthy choices, and agencies reported providing 3,982 referrals of high risk individuals to other health and social services.

Six agencies reported survey results related to this outcome. In their sample of 1,065 high risk individuals, 81% indicated “yes” to the question: “If I were going to have sex I would talk to my partner about using a condom.”

Based on the outputs and survey results, there is evidence of reached populations making informed and healthy choices around sexual health and risk behaviours. There is also evidence of changes in the knowledge and behaviour of reached high risk populations.

Evaluation Question 3: What is the evidence that PLWH have increased capacity to lead healthier and safer lives?

The evidence for this evaluation question is linked to the following three intermediate term outcomes in the health promotion fund approach:

PLWH access services outside of ASOs (i.e. Medical and social services).

Agencies supported PLWH to access services outside of ASOs by providing 7,616 referrals of health promotion program clients to health and community supports in other agencies. Seven agencies reported survey results related to this outcome (n=62) in which 95% of respondents strongly agreed or agreed that “Because of the Agency support, I feel I am able to get the health services I need.” There is evidence that PLWH access services outside of ASOs.

“One of the residents during this reporting period had extreme difficulties with anger management. Staff was able to advocate for him and the Psychologist from the [HIV Clinic] was able to find him an intense three month anger management program that he could attend for free rather than having to pay for it.”

PLWH and those affected are satisfied with the services provided by ASOs.

Six agencies provided survey results (n=59) in which 97% strongly agreed or agreed that they are satisfied with the quality of services received at the agency. While the surveys conducted with those affected did not directly ask about satisfaction, the results presented previously in which 100% of respondents agreed that the agency provides them and their loved one with non-judgmental supports

can be taken as a proxy indicator of satisfaction. There is evidence that PLWH and those affected are satisfied with the services provided by ASOs.

PLWH are actively involved in activities that enhance and maintain their health.

Agencies reported involvement of PLHW in organizing nutrition programs, organizing and attending conferences such as Alberta's Positive Voice Conference and the Alberta Harm Reduction Conference, providing presentations, volunteering at weekly drop-in programs, taking on roles as resident representatives on boards and committees, and assisting with peer support programs.

It can also be said that residents and outreach clients of assisted living facilities who are in transitional care (10/7 per six month period) are involved in activities to enhance and maintain their health as they are supported towards the goal of healthy, independent living.

Seven agencies reported the following survey results related to this outcome (n=62): 86% of PLWH strongly agreed or agreed that they are invited to participate in decisions about services they receive; 70% strongly agreed or agreed that staff members supported them to be in contact with family and friends.

"Many residents have family members visit weekly or a couple of times a week. Family members are encouraged to join residents for the evening meal when they visit."

There is evidence that PLWH are actively involved in activities that enhance and maintain their health.

Analysis of Evaluation Question 3: What is the evidence that PLWH have increased capacity to lead healthier and safer lives?

Together, the above three outcomes provide evidence that PLHW have increased capacity to lead healthier and safer lives.

Evaluation Question 4: What is the evidence that people who use drugs have increased capacity to lead healthier and safer lives?

The evidence for this evaluation question is linked to the following intermediate term outcome in the harm reduction fund approach:

People who use drugs access the services and support they need and are making safer decisions.

There is a variety of data supporting the fact that people who use drugs access the services and support they need. There were 2,600 outreach occasions serving PWUD that were not directly related to needle exchange, reaching 20,070 individuals, and 158 support occasions with 3,330 contacts. The harm reduction programs reported 50,585 contacts with harm reduction program clients overall (including exchange-related contacts). The number of tests provided (2,278) is another indicator of safer decision making. There were 1,112,883 needles reported distributed in 2008/09, which is a further indicator of safer decision making.

Five agencies reported having used the Harm Reduction Client Survey (n=237). Of this sample, 77% said they make safer decisions when using drugs and 71% said they make safer decisions when having sex than before they started using the needle exchange program. There is evidence that people who use drugs accessed the services and support they need and are making safer decisions, and there is evidence that people who use drugs have increased capacity to lead healthier and safer lives.

Evaluation Question 5: *What is the evidence that the community has increased knowledge of HIV and related issues, as well as increased support for PLWH, people who use drugs and high risk populations?*

The evidence for this evaluation question is linked to the following intermediate term outcome in the creating supportive environments fund approach:

The commitment and capacity of other organizations and sectors to address HIV is increased.

ACHF funded organizations engaged on a wide variety of community action issues in order to influence the commitment and capacity of other organizations and sectors to address HIV; page 17 describes the issues in which ASOs are engaged. When engaging on issues, ASOs used a variety of methods to improve other organizations' and professions' capacities to address HIV: partnerships; training of professionals; offering student practicum placements; preparing resources and tools; needle exchange program van ride-alongs, and; activities to influence policy. These methods were used 1,146 times to increase the commitment and capacity of other organizations and sectors to address HIV.

A key measure of the increased commitment of other organizations and sectors is the number of partnerships. In 2007/08, there were 125 collaborative partnerships reported by ACHF funded agencies, while in 2008/09 there were 216 partnerships reported. There are additional partnerships noted in all sectors, but most notably health, education, housing, justice and industry. The number of new partnerships is an indicator of increased commitment of other organizations and sectors to address HIV.

Six agencies reported survey results examining capacity to address HIV among the practitioners/professionals/service providers who attended workshops. Of the sample of 223, 91% said that as a result of this workshop, they are more encouraged to talk about HIV testing with clients/peers and 89% said that they are more comfortable talking about safer sex practices with clients/peers.

There is evidence of increased commitment and capacity of other organizations and sectors to address HIV. Regarding the evaluation question, there was evidence provided earlier of increased knowledge among practitioners/professionals/service providers about HIV and related issues (page 29), and evidence of increased commitment and capacity provides confirmation of increased support for PLWH, people who use drugs and high risk populations.

Evaluation Question 6: *What is the evidence that the organizational capacities of ASOs have been enhanced through ACHF funding?*

The evidence for this evaluation question is linked to the following two intermediate term outcomes in the strengthening community-based organizations fund approach:

Diverse funding sources are attained.

Agencies reported a total of 119 other sources of funding, with a range between agencies of 1-73 sources (73 includes individual donors). In total, there was \$2,699,655 in other funding reported by the agencies, from nine types of funding sources. There is evidence that diverse funding sources have been attained by the ASOs.

ASOs provide evidence-based programming that is responsive to diversity, cultures, client feedback, evaluations, epidemiology and demographics of clients.

There is ample demonstration that ASOs are providing programming that is evidence-based and responsive. From Table 3 (page 8), agencies are serving and responding to many diverse target populations and cultures, and there is evidence that they are engaged in needs assessments and research projects to learn more about how best to work with individuals such as people from countries where HIV is endemic and Aboriginal people. Table 21 (page 23) demonstrates that agencies are highly engaged in seeking and receiving feedback from clients in order to be responsive, and Table 22 (page 23) demonstrates that agencies are conducting many forms of inquiry to seek input and evidence into their programming. They held discussions at ACCH meetings called “Best Practice Think Tanks” in which they reviewed literature on topics and discussed what it means for their service, and had skills building sessions learning about Hepatitis C and HIV co-infection, working with communities from countries where HIV is endemic, and prevention programs for transient populations, for example.

“[We have] been working with the university on a CIHR funded research study on Engaging African Communities in a Community Response to HIV. As part of our ACHF funded community development work connected to this study, we have been sharing the research results with other service providers and members of African communities in order to build a greater understanding of service challenges facing these communities and to form new partnerships to engage community leaders and increase access to culturally appropriate services for these communities. A Community Dinner and Roundtable was held to disseminate study results. The dinner was attended by 34 African newcomer community leaders and members, as well representatives of immigrant and health agencies. Participants were then broken up into small group discussions of their reactions to the research and what they thought needed to be done to improve service provision. Eleven individuals offered to provide letters of support for a funding proposal, twelve individuals/organizations were interested in forming new partnerships to address HIV in African newcomer communities and fifteen individuals/organizations were interested in joining a Community Advisory Committee to lead this work.”

In addition to the above evidence provided through other outputs, ASOs were asked to respond directly to how they ensure that their agency provides programming that is responsive to diversity, cultures, client feedback, evaluations, epidemiology and demographics of clients. Some agencies responded in a summary format to this question, but others provided information particular to their responsiveness to each of these factors that provided additional evidence that this outcome is being achieved. One agency, for example, described 10 methods or tools used routinely to learn about what they are doing well and what they need to change. There is evidence that ASOs are providing evidence-based programming that is responsive to diversity, cultures, client feedback, evaluations, epidemiology and demographics of clients.

Analysis of Evaluation Question 6: *What is the evidence that the organizational capacities of ASOs have been enhanced through ACHF funding?*

The Alberta Community HIV Fund provides operational funding, which includes funding for management, overhead and administrative costs. In an era when many other funding opportunities are project based and, therefore, do not provide funding for ongoing operational expenses, the fact that ACHF supports these expenses then leads to the expected outcome that organizational capacities of funded organizations will be enhanced as they have stable funding to engage in various forms of organizational development. Enhanced organizational capacities are indicated by the attainment of the two outcomes above: attaining diverse funding sources and providing evidence-based programming that is responsive. With both outcomes related to this evaluation question being met, there is evidence that the organizational capacities of ASOs have been enhanced through ACHF funding.

Evaluation Question 7: *What is the evidence that collaborative partnerships resulted in an expanded reach of HIV related services and support?*

The evidence for this evaluation question is linked to outcomes under four fund approaches.

Prevention

Partner organizations are working to prevent HIV with their clients.

The number of partnerships reported (216), the type of organizations involved and the descriptions of partnerships indicates clearly that there are partnerships focussed on HIV prevention. The evidence that partners are actively working on HIV prevention also comes from qualitative descriptions of the activities of and results from partnerships. There is evidence that partner organizations are working to prevent HIV with their clients.

Regarding outreach at several community programs: “Staff at the facility are better able to meet the needs of target population, thereby decreasing barriers to access.”

Harm Reduction

An active network of NGOs, government agencies and other stakeholders collaborates to address harm reduction issues.

The Non-Prescription Needle Use Consortium (NPNU) is an alliance of approximately 35 representatives from government sectors and community agencies formed to reduce the harms associated with non-prescription needle use. Many of the ASOs participate in the NPNU and its various task groups. The NPNU is an active network of NGOs, government agencies and other stakeholders that collaborates to address harm reduction issues; this outcome is being achieved.

Harm reduction services are offered and accessed more widely through community venues (e.g. hospitals, pharmacies, prisons).

Table 11 (page 15) indicates that there are at least 43 locations for needle exchange offered by the six needle exchange programs funded through ACHF. Locations include pharmacies, mobile vans, other agencies and walking outreach. There is evidence that harm reduction services are offered and

accessed more widely through community venues, as the number of locations increased from 2007/08 to 2008/09.

Creating Supportive Environments / Strengthening Community Based Organizations

An increasing number and range of organizations and sectors are involved in addressing HIV.

One measure of the increasing number and range of sectors is the number of partnerships. In 2007/08, there were 125 collaborative partnerships reported by ACHF funded agencies. In 2008/09, there were 216 collaborative partnerships reported. There are additional partnerships noted in all areas of focus, but most notably in health, education, housing, justice and industry. There were also additional partnerships noted in all of the sectors inquired about (private, public, not-for-profit and other). There is an increasing number and range of organizations and sectors involved in addressing HIV.

Analysis of Evaluation Question 7: *What is the evidence that collaborative partnerships resulted in an expanded reach of HIV related services and support?*

All outcomes related to partnerships have been achieved. In addition to the evidence presented above specific to the outcomes, agencies estimated that other organizations provided 4,635 hours of loaned staff time to their agency in providing presentations, doing joint outreach, sitting on committees, etc. There is evidence that collaborative partnerships resulted in an expanded reach of HIV related services and support.

“Working closely with the YMCA settlement services has expanded our outreach to PLWHA and those affected by HIV from endemic countries.”

“It was beneficial to work with the sexual health nurses to organize workshops in rural areas, rather than try to do it on our own. The sexual health nurses had the contacts and relationships with service providers from their respective areas.”

Evaluation Question 8: *How have target population members been involved in program development, delivery and evaluation, and in the governance of ASOs?*

The following outcome is found under all five funding approaches:

Target population members are involved in program planning, evaluation, delivery and governance.

Table 24 (page 25) and the descriptions that followed the table provide evidence of the involvement of target populations. It is clear that target population members are involved in every agency, through informal and formal opportunities to express opinions about programming, volunteering in program delivery, sitting on committees and boards, and being employed by agencies. Target population members participate in their own groups and committees (user groups, Alberta Positive Voice Conference Planning), and play active roles in every agency. There is evidence that target population

members are involved in program planning, evaluation, delivery and governance through a wide variety of activities.

Evaluation Question 9: What is the evidence of changes to HIV-related policy and practice within other organizations and sectors?

The evidence for this evaluation question is linked to the following intermediate term outcome in the creating supportive environments fund approach:

Policy and programs are adapted to meet the needs of PLWH, people who use drugs and those at risk.

As described on page 19, ASOs provided 12 examples of new policies or practices within other organizations or sectors that impact HIV programming. There is evidence that policy and programs are adapted to meet the needs of PLWH, people who use drugs and those at risk, and there is evidence of changes to HIV-related policy and practice within other organizations and sectors.

Evaluation Question 10: What lessons have we learned about the effectiveness of the services provided?

This evaluation question can be examined through two lenses: what lessons were learned regarding the barriers encountered in HIV programming, and what lessons were learned about approaches that worked. The barriers are broader aspects or themes that challenge the work of the agencies in addressing HIV in their communities. The approaches tend to be more precise and specific methods or techniques that were identified as effective.

Barriers

- Stigma and discrimination – This was described in terms of client fear of revealing their HIV status, and experiences of stigma and discrimination in employment, healthcare and housing settings. The following quotation illustrates the challenges of stigma and discrimination:

“At times, it has been difficult to find the dental services that many of the residents desperately need. It would seem that some dentists are still not comfortable working with people living with HIV, despite the advocacy and awareness building that goes on in this area. Staff has had to work diligently during this reporting period to find willing and able dental professionals to complete extensive work for three of the residents in the program.”

- Safety – This was described in terms of too few staff to open the office safely, inability to reach clients who live in “the bush,” or walking outreach only being available when two staff members are available for safety reasons.
- Language – This was described by several agencies related to the increase in clients from countries where HIV is endemic.

“Because [our community’s] immigrant population is growing, we are increasingly encountering language barriers. A partnership with Immigrant Services is in the works, but due to the confidential nature of our work, this is not always the best approach.”

- Access to services – This was described in terms of challenges with having office hours when clients are more active (e.g. evenings), struggles to provide services in rural areas, need for 24 hour needle exchange access, difficulty reaching needle exchange clients in areas outside of the downtown core.

“As poor and homeless people are squeezed out of the downtown core by gentrification, it is harder to find them to provide services as we are not funded to run the program on a city-wide basis.”

- Reaching Aboriginal populations – This was described in terms of local Aboriginal organizations or partners having shut down, the importance of learning cultural practices, and learning how to organize events that work for Aboriginal communities.

Approaches That Worked

- Assisting with basic needs and/or providing tangible benefits to clients, such as bus tickets, draws for grocery gift cards, honouraria, snacks, prizes, or comfort packs (most of these services are not funded by ACHF). Assisting with basic needs may include clothing, referrals to shelter, assistance with minor cuts and wounds, and providing transportation to appointments.
- Altering service hours, such as evening office hours, offering groups on weekends, evening workshops, evening outreach, and finding partners to offer 24 hour access to needle exchange.
- Providing services and supports that are respectful of cultural values.
- Ongoing and repeated efforts to educate practitioners/professionals/service providers on HIV, universal precautions, harm reduction and the effects of stigma and discrimination. Agencies stressed the ongoing need to educate emergency medical staff, police, dental and medical offices, nurses, city groundskeepers, mental health services staff, and staff at other community non-profit agencies.

“We were being told that some agencies were reluctant to serve HIV and HCV positive clients. Many staff, even though receiving information from our outreach nurses one on one, were still afraid to deal with HIV+ clients. Therefore we met with the ED [Executive Director] of the Women’s Shelter and arranged for a staff in-service to educate the newer staff on the universal precautions and working with HIV+ persons.”

- Partnerships to reach populations. Partnerships are often a first step to establishing relationships with populations, through the agencies that already serve that population. Partnerships help ACHF funded agencies learn more about the population as well as reaching them in a manner that is supported by those who know the population best.
- Outreach and support events and programs that reach target populations where they meet (e.g. bars, the street). Outreach is a key strategy to increase reach to populations that may not

identify themselves as at-risk, so going to where they are is necessary. New in the 2008/09 reports was repeated mention of the importance of street level or walking outreach. Support occasions where clients are may include institutions, hospitals or their homes.

“We have built rapport with clients through the social workers at the local hospital in an effort to maintain services with clientele once they go home. We are currently supporting a client in her home through outreach.”

- Responsiveness to input, adjusting programs, creating resources and addressing emerging populations. Agencies must not just receive input but must respond to input in order for it to be effective. Agencies demonstrated ongoing improvement in their responsiveness, in adjusting programming and resources to the input and needs of target populations. Specific examples related to requests regarding certain harm reduction supply types, requests for crack pipes and the development of new initiatives related to people from countries where HIV is endemic.

Evaluation Question 11: What emerged as good practice for each of the five ACHF funding approaches?

The good practices are more general activities in each funding approach that were consistent among agencies and had evidence to support their effectiveness. In some cases, the good practices are an expansion of the more detailed approaches. An example of this would relate to partnerships; the approach related to partnerships was specific to reaching populations while the good practice speaks more to the overall practice and purpose of partnerships.

Crossing All Fund Approaches:

- Ongoing attention to evidence based practice, using service recipient feedback, routine data collection and other methods of evaluating needs and approaches
- Target population involvement (supports clients’ progress, supports agency work, builds in feedback)
- Partnerships that are collaborative, engage other sectors and organizations, and build support for the work and for clients

Creating Supportive Environments:

- Training of practitioners/professionals/service providers on HIV, universal precautions, harm reduction, and stigma and discrimination
- Working with other community partners to co-host community events such as fundraisers, conferences and workshops
- Participating in committees and networks that raise awareness, build partnerships and impact policy and practice in other organizations and sectors

Health Promotion:

- Providing basic supports such as vouchers, food, clothing, bus tickets and transportation
- Ensuring agency services are accessible including, for example, evening and weekend support and support in hospitals and institutions

Harm Reduction:

- Outreach through vans, at other locations, on foot, with extended hours

- Attention to new or evolving transmission methods and prevention through additional supply distribution (e.g. crack pipes)

Prevention:

- Outreach to target populations through events and programs that engage populations where they meet (e.g. bar blitzes, bath houses, other agencies)
- Presentations to at risk populations, with surveys demonstrating increased knowledge and intended behaviour change
- Access to free safer sex supplies

Strengthening Community Based Organizations:

- Ongoing staff training, including basic training as well as training on emerging issues
- Use of volunteers to support the work and assist in creating supportive environments.

Discussion and Recommendations

The ASOs are providing increasing evidence that they are meeting the outcomes of the Alberta Community HIV Fund. There is reliable evidence that the vast majority of outcomes in the ACHF Evaluation Framework have been achieved (26 of 27). The remaining discussion and recommendations are organized by fund approach.

Prevention

Overall, there is less mention of work with Aboriginal people and communities than in previous evaluations. It is acknowledged that contacts with and service to Aboriginal people may, in fact, be higher than reported if a workshop was reported for “young Aboriginal women,” for example but coded to “youth” or if an individual can be identified with more than one target population or doesn’t identify as Aboriginal. There were only five partnerships reported with Aboriginal organizations and 27 events/workshops for Aboriginal people or communities. Several agencies noted barriers to reaching Aboriginal people or working with Aboriginal communities. The impression is that there was less emphasis or focussed work with this population in 2008/09 than was reported in previous years.

Recommendation: Given the rates of HIV infection among Aboriginal people, ASOs should ensure that there is Aboriginal focussed prevention programming being offered and reported upon.

Health Promotion

This evaluation provides increased data and evidence regarding contacts with clients in the health promotion program, who should be people living with HIV. The total contacts and the high number of referrals in the health promotion program indicate active connection with and services provided to this population. Yet, there is still difficulty in determining what specific supports are available in ASOs for people living with HIV. Most program explanations offered general descriptions such as access to facility, counselling and emotional support or transportation but were not distinguished by target population because these services are available to high risk populations, people who use drugs and people living with HIV.

The reality is that PLWH are often transient in that they move in and out of communities and/or their health stabilizes so they may not need ASO services again for some time. Agencies provide open-door services to many target populations in which each contact with an individual may not be distinguishable by HIV status. However, it is also true that agencies are able to identify a specific number of health promotion clients, so some individuals are identified as HIV positive. Some agencies, for example, listed specific programs for PLWH in which only that population attended (such as peer support or nutritious lunch programs), and then also described their more generally offered services (such as access to facility) inclusive of more populations and including contacts with people who may be HIV positive.

Recommendation: ASOs need to identify a common method across the health promotion programs to capture contacts by type of services within the health promotion program specific to people living with HIV in order to differentiate as much as possible distinct services and contacts with PLWH.

Recommendation: Use the ACHF narrative report to focus ASO reporting regarding PLWH on the outcomes expected for that target population so agencies are prompted to consider other evidence (including stories) they can provide with respect to the outcomes.

Harm Reduction

Reading the reports of the harm reduction programs, there is a sense that these programs are continually evolving, searching for new ways to provide services and new supplies that are needed by the community. Their practice evolves and their committees continue to promote learning from each other and new services to meet changing needs. In 2008/09, several programs identified new or expanded services they wished to provide, such as more walking outreach and 24 hour access to needle exchange. Now having a series of ACHF evaluations that describe the evolution of harm reduction programming, there is little doubt that they will continue to work towards these desired new or enhanced services for their communities.

Recommendation: Harm reduction programs should continue to innovate and respond to the needs of their target populations as they have historically.

Creating Supportive Environments

Overall, the work and results in creating supportive environments are much better reported in 2008/09 than in previous years due to focussed questions in the new narrative report. The questions prompt agencies to report their actions and approaches to influence policy and practice, whereas in the past they may not have described their committee work in that manner, for example. This has provided more rich information regarding the efforts to create supportive environments.

There is increased evidence in 2008/09 of agencies being more engaged in repeated and ongoing training of other organizations and sectors to increase their knowledge and capacity. While this is a valuable activity that is clearly producing results, it may not be sustainable for agencies to engage in this level of service in the future, particularly if the demands continue to increase. It may be more advantageous and sustainable over time to consider other ways of achieving similar results. One option may be to consider providing such ongoing training on a fee for service basis, thereby compensating agencies for their time and expertise. A second option is to follow the lead of the ASO who reported working at the provincial level with professional associations to get the necessary HIV, harm reduction

and universal precaution information included in professions' newsletters, mandatory curriculums and upgrading courses.

Recommendation: ACCH should coordinate a review of the professions, practitioners and service providers who are in need of ongoing and repeated training to determine if action at the provincial level would be more effective in getting necessary HIV related information included in mandatory curriculums.

Strengthening Community-Based Organizations

There is a striking difference between the 2004/07, 2007/08 and 2008/09 evaluations in terms of the reduced emphasis on staffing challenges. In 2008/09, only one agency reported on the impact of being short-staffed. This is likely reflective of the economic slow-down, as well as the new narrative reporting format (less narrative story-telling).

Agencies were asked to report many outputs in the strengthening community-based organizations funding approach, which they did with increasing consistency through the year. Their efforts in managing human resources, program planning/implementation/evaluation, and partnership are well documented and solid.

The collection, tallying and analysis of the data for this evaluation highlighted some issues with the new narrative report. Some questions elicit similar information, some valuable information (such as detail regarding committees, coalitions, working groups) is not consistently reported, and some sections require further definition and instruction to clarify what information is being sought.

Recommendation: ACCH should continue to review and refine the Evaluation Framework and implementation strategies, including linkages, definitions, data collection tools and data collection methods on a yearly basis.

Recommendation: ACHF should review the narrative reporting form to align with any changes to the Evaluation Framework and to address the issues highlighted through this evaluation.

Appendix A: Evaluation Framework

Prevention Initiatives

TARGET POPULATIONS: high risk populations

Goals 1. Prevent new infections 2. Slow the progression of the disease and improve quality of life. 3. Reduce the social and economic cost of HIV/AIDS.

Inputs Staff, volunteers, time, money, research/evidence, materials, supplies, partners

Key Activities Outreach Education Distribution of Supplies Partnership Development

Outputs	# outreach activities	# target population actively involved	# condoms	# partners
	type of outreach activities	activities tar pop involved in		sectors and areas of focus represented
	# contacts through outreach	# educational/awareness activities		description of partnership activities
	# support activities	types of educational /awareness activities		
	type of support activities	# people reached at educational /awareness activities		
	# contacts through support activities	range of topics at educational/awareness activities		
	# referrals	# resources used		
	types of referrals	# resources reproduced		
	# of tests	# resources distributed		
	# pre/post test counseling sessions	types of resources		

Short Term Outcomes High risk populations are more knowledgeable about HIV/AIDS including transmission, prevention and risk behaviour.

High risk populations have access to safer sex resources (condoms, etc.), prevention messaging and social support.
ASOs have partnerships for HIV prevention initiatives directed at high risk populations.

Intermediate
Outcomes

Reached populations make informed and healthy choices around sexual health and risk behaviours.

Partner organizations are working to prevent HIV with their clients.
Target population members are involved in program planning, evaluation, delivery and governance.

Long Term Outcomes

The number of new HIV infections is stable or decreased.

Health Promotion

TARGET POPULATIONS: PLWH and those affected

Goals	1. Prevent new infections 2. Slow the progression of the disease and improve quality of life. 3. Reduce the social and economic cost of HIV/AIDS.		
Inputs	Staff, volunteers, time, money, research/evidence, materials, partners		
Key Activities	Care & support	Education	Partnership Development
Outputs	types of services provided	# target population actively involved	# partners
	# contacts for each type of service	activities tar pop involved in	sectors and areas of focus represented
	# clients	demographics of reached populations	description of partnership activities
	# referrals	# educational/awareness activities	
	Type of referrals	types of educational /awareness activities	
	# outreach activities	# people at educational /awareness activities	
	type of outreach activities	range of topics at educational/awareness activities	
	# outreach contacts	# resources used	
	# PLWH served in 24/7 intensive care	# resources reproduced	
	# days of 24/7 intensive care	# resources distributed	
	# PLWH served in long term care	types of resources	

PLWH (residents) served in transitional care
PLWH (non-residents) served in transitional care
#PLWH who passed away

Short term Outcomes

PLWH and those affected by HIV/AIDS are more knowledgeable about HIV related issues.
PLWH and those affected by HIV/AIDS have access to appropriate and non-judgmental supports in ASOs, including other PLWH.

PLWH have access to 24/7 intensive care and end-of-life care.

Intermediate Outcomes

PLWH access services outside of ASOs (i.e. Medical and social services).

PLWH and those affected are satisfied with the services provided by ASOs.

PLWH are actively involved in activities that enhance and maintain their health.

Target population members are involved in program planning, evaluation, delivery and governance.

Long Term Outcome

PLWH have improved health.

Harm Reduction

TARGET POPULATIONS: people who use drugs

Goals 1. Prevent new infections 2. Slow the progression of the disease and improve quality of life. 3. Reduce the social and economic cost of HIV/AIDS.

Inputs Staff, volunteers, time, money, research/evidence, materials, supplies, partners

Key Activities Outreach Education Distribution of Supplies Partnership Development

Outputs	# harm reduction program clients	# target population actively involved	type of supplies out	Health Authority partnership
	# contacts outreach	activities tar pop involved in	# needles out	Description of partnership activities
	Type of outreach activities /events	# educational/awareness activities	# locations/access points	# partners
	# outreach activities /events	types of educational /awareness activities	types of locations/access points	sectors and areas of focus represented
	# support activities	# people at educational /awareness activities		
	type of support activities	range of topics at educational/awareness activities		
	# support contacts	# resources used		
		# resources reproduced		
		# resources distributed		
		types of resources		

Short term Outcomes Individuals have increased knowledge of and access to harm reduction services and information.

There is appropriate availability of harm reduction supplies.

Intermediate
Outcomes

People who use drugs access the services and support they need and are making safer decisions.

An active network of NGOs, government agencies and other stakeholders collaborates to address harm reduction issues.

Harm reduction services are offered and accessed more widely through community venues (e.g. hospitals, pharmacies, prisons).

Target population members are involved in program planning, evaluation, delivery and governance.

Long term

Harm reduction is accepted as a legitimate approach to drug use and HIV prevention in the community.

There are reduced negative consequences of drug use in communities.

People who use harm reduction programs have improved health.

Creating Supportive Environments

TARGET POPULATIONS: community members and practitioners/professionals/service providers

Goals 1. Prevent new infections 2. Slow the progression of the disease and improve quality of life. 3. Reduce the social and economic cost of HIV/AIDS to Canadians.

Inputs Staff, volunteers, time, money, research/evidence, materials, partners

Key Activities Education/Awareness Media Partnership Development Policy Development

Outputs	# target population actively involved activities tar pop involved in	Types of media # media coverage	# partners sectors and areas of focus represented	range of community action issues methods used to improve other organizations' & professions' capacities to address HIV
	# educational/awareness activities	website updates	description of partnership activities	New policies or practices within other organizations or sectors, jointly developed, that impact HIV programming
	types of educational /awareness activities			range of partners/orgs reached from a variety of sectors to address determinants of health
	# people at educational /awareness activities range of topics at educational/awareness activities # resources used # resources reproduced			

resources distributed
types of resources
ride-alongs
agencies represented on
ride-alongs

Short term Outcomes	Community members and partners have up-to-date information on HIV/AIDS and related issues. Community members and partners have awareness & knowledge of HIV/AIDS.
Intermediate Outcomes	The commitment and capacity of other organizations and sectors to address HIV is increased. An increasing number and range of organizations and sectors are involved in addressing HIV. Target population members are involved in program planning, evaluation, delivery and governance. Policy and programs are adapted to meet the needs of PLWH, people who use drugs and those at risk.
Long Term Outcomes	The community has increased awareness of and support for PLWH, people who use drugs and high risk populations. The social barriers that prevent PLWH and those at risk, including people who use drugs, from accessing health care and/or social services are reduced or eliminated.

Strengthening Community Based Organizations

TARGET POPULATIONS: Community based organizations

Goals	1. Prevent new infections 2. Slow the progression of the disease and improve quality of life. 3. Reduce the social and economic cost of HIV/AIDS.		
Inputs	Staff, volunteers (board), time, money, research/evidence, partners, technology		
Key Activities	Manage Human Resources	Planning / Implementation / Evaluation	Partnership Development
Outputs	# volunteers # volunteer hours volunteer activities # staff # staff retained for 2 or more years # students variety of student study areas # board positions filled # training events for both staff & volunteers # attendees at each training event, each person training event topics	# funding sources Types funding sources total dollar amount from other sources methods of receiving feedback from service recipients routine data collection and analysis range of evidence that informs programming # board meetings # planning and evaluation documents	# partners sectors and areas of focus represented description of partnership activities partnership with other ACHF funded organizations

Evaluation Questions:

1. Are the short term outcomes in the Provincial Evaluation Framework being achieved?
2. What is the evidence of changes in the knowledge and behaviour of reached high risk populations? (Prevention)
3. What is the evidence that PLWH have increased capacity to lead healthier and safer lives? (HP)
4. What is the evidence that people who use drugs have increased capacity to lead healthier and safer lives? (HR)
5. What is the evidence that the community has increased knowledge of HIV and related issues, as well as increased support for PLWH, people who use drugs and high risk populations? (CSE)
6. What is the evidence that the organizational capacities of ASOs been enhanced through ACHF funding? (SCBO)
7. What is the evidence that collaborative partnerships resulted in an expanded reach of HIV related services and support?
8. How have target population members been involved in program development, delivery and evaluation, and in the governance of ASOs?
9. What is the evidence of changes to HIV-related policy and practice within other organizations and sectors?
10. What lessons have been learned about the effectiveness of the services provided?
11. What emerged as good practice for each of the five ACHF funding approaches?